

State of Tennessee

Department of Commerce and Insurance

Public Comments on Essential Health Benefits

State of Tennessee

Department of Commerce and Insurance

Tess St. Clair,

Company/Organization Not Supplied

I work in health care financing and have been watching, waiting and listening to everything about single-payer health care, and PPACA.

My partners and I started out by talking to politicians, till we were blue in the face, about why health care financing is in the state it's in, and what the solutions are. Once we were out of breath, we realized: this is America, where free enterprise and the private sector will solve the problem, NOT politicians, and not government.

- 1. Tennessee is already part of a health care compact, so I'm very curious to know how any State decisions would fit in with the compact.*
- 2. I can understand the need for a compact when there are shared natural resources involved, but not MY HEALTH.*
- 3. TennCare is an obamanation (yes, pun intended). It is the "drug pusher" destroying our State. So, why would anyone think that making it bigger is better?*
- 4. If hospitals are willing to accept TennCare and Medicare levels of reimbursement and the head aches that accompany both of them, why don't they just offer those prices to the public that is uninsured or underinsured when they walk in the door?*
- 5. Finally, I am against the Health Care Compact and Insurance Exchanges because:*
 - A. They are straight out of PPACA.*
 - B. The fines to employers will be 50% more, if implemented by the State*
 - C. They are both BIG government solutions and, as said earlier, TennCare already sucks. It is degrading to the taxpayers of Tennessee, and actually encourages having children out of wedlock, rather than doing any planning. Let's do something that actually builds character, and dignity.*

My partners and I have been successful at building our own, free market, solution and it's working out very cost-effectively for everyone. If you would like to discuss, please let me know.

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State of Tennessee

Department of Commerce and Insurance

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End of Tess St. Clair's Comment

State of Tennessee

Department of Commerce and Insurance

Joseph Interrante,

Nashville Cares

I am writing on behalf of Nashville Cares, Tennessee's largest AIDS service organization representing the needs of more than 2,500 people living with HIV and AIDS and their families in Middle Tennessee. We urge you to ensure that the Essential Health Benefits (EHB) benchmark for the health insurance exchange established under the Patient Protection and Affordable Care Act guarantees adequate coverage for people living with HIV and AIDS and other vulnerable populations.

In 2014, thousands of people with HIV and AIDS will have access to private insurance -- many for the first time. To be meaningful, insurance coverage must include comprehensive services that people living with HIV and AIDS need to stay healthy. As enumerated below, such services are necessary to ensure that HIV-infected individuals are diagnosed early, stay in regular care and treatment and realize the life saving and cost effective benefits of HIV treatment. Further, because effective treatment prevents HIV transmission, comprehensive care for people living with HIV and AIDS also benefits the state's public health by reducing new HIV infections.

We urge you to ensure that the EHB in both individual small-employer group health insurance plans include at minimum the following:

Prescription Drugs

A prescription drug formulary that supports the current standard of care for people living with HIV and AIDS (found at <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx>) and the standards of care for other chronic diseases. People living with HIV and AIDS rely on a minimum of three drugs from the antiretroviral drug class to effectively suppress the virus. Because the specific combination of drugs varies significantly by individual health history, plans that cover only one or even a few drugs in each category or class covered by the benchmark would not support the current standard of HIV care. Explicit provisions, such as those provided for the six "protected" classes on the Medicare Part D drug program, are necessary. In addition, prior authorization requirements and other utilization controls (such as "special permission" for non-preferred brand or specialty drugs) should be limited to ensure access by physicians and their patients to the appropriate standard of HIV therapy. We also urge inclusion of newer, more effective viral hepatitis medications, given the rates of hepatitis co-infection among people with HIV infection, as well as inclusion of medications to control side-effects and treatment of other co-occurring conditions as outlined in the NIH guidelines.

Ambulatory Patient Services

Access to HIV experts, including those trained in infectious diseases, and a range of other specialists is critical to treat successfully HIV disease and other co-occurring conditions common among people with HIV and AIDS. The benchmark should prevent insurance plans from making it unduly burdensome to access specialists, for instance through repeated preauthorization or high co-payments for specialty care.

Mental Health and Substance Use Treatment

Access to the range of services effective for treating mental illness and substance use disorders is critical to prevent inpatient hospitalizations and to support people with HIV and AIDS adhering successfully to prescribed care and treatment. The EHB should comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, as well as limit variation in the scope of the mental health and substance abuse services offered among insurance plans.

Laboratory Services

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

The established standard of care for people with HIV and AIDS recommends laboratory tests every three to six months to assess an individual's response to HIV therapies, as well as the development of co-occurring conditions as a result of treatment or disease progression. The EHB should require coverage of this standard for services without the imposition of service limits driven by price.

Disease Management and Rehabilitative/Habilitative Services

Although not regularly covered or uniformly defined by insurance plans, case management plays an important role in helping people with HIV and AIDS access services to stay healthy and reduce the use of more intensive and more costly health care services. We urge the inclusion of case management services. We also recommend defining case management to include community-based care and services system coordination and navigation, along with HIV/AIDS treatment and care adherence counseling, education and support.

Preventive Services

The EHB should, at minimum, cover all services with an A or B rating from the United States Preventive Services Task Force without variation among insurance plans. These include but are not limited to sexually transmitted infection counseling, FDA-approved contraception and contraceptive counseling, and domestic violence screening and counseling. It should also include annual HIV screening and counseling (currently with a C rating) for men as well as women.

Benefit Limitations or Substitutions

The EHB benchmark should prohibit insurance companies from limiting access to medically necessary health care services, especially for individuals with higher cost chronic conditions such as HIV/AIDS, through dollar or visit limits on essential services, condition-specific restrictions, excessive cost-sharing, and/or unduly burdensome utilization management and prior authorization requirements. Such practices penalize people with HIV/AIDS and other chronic conditions who rely upon routine medical visits and laboratory monitoring to stay healthy and prevent disease progression.

The benchmark should also prohibit the substitution of benefits within or across the ten benefit categories specified in the ACA, since such substitutions could result in limiting or eliminating services that are essential to people living with HIV and AIDS.

Thank you for the opportunity to comment on the Essential Health Benefits Plans under consideration by the Department. As you narrow your selection, we would appreciate the opportunity to review the specific benefit provisions of these plans. Please contact Nashville CARES with any questions you may have. We look forward to working with you to design a benchmark that meets the needs of people with HIV/AIDS and other vulnerable populations in Tennessee.

End of Joseph Interrante's Comment

State of Tennessee

Department of Commerce and Insurance

Chris Lovell,

Dialysis Clinic, Inc.

Dialysis Clinic Inc. (DCI) appreciates the opportunity to provide comments on the Essential Health Benefits for Tennesseans. DCI is a 501(c)(3) nonprofit dialysis provider treating approximately 14,000 patients at 207 dialysis facilities in 27 states. Our company was founded in Nashville Tennessee over 40 years ago and the corporate offices remain in Nashville. In the State of Tennessee we operate 28 dialysis facilities, serving approximately 2,000 patients.

We appreciate the Administration's efforts in requesting comments to develop essential health benefits. We feel strongly that plan options include coverage of ESRD, we urge you to clarify the definition of "essential health benefit" to explicitly include "coverage of ESRD." ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease ("CKD"), which is reached when an individual's kidney cannot sustain life. In this case, the individual has only two treatment options: either kidney transplantation or, more typically, dialysis (given the shortage of available kidneys).

If these treatments are not accessible or are delayed, the individual will die. Thus, by definition, coverage of ESRD is an "essential health benefit." Without such an express statement, a state plan could theoretically forgo providing critical life-saving ESRD treatments, the treatments could be delayed or limited, or there could be an increase in significant out-of-pocket costs for patients or increases in travel times to dialysis centers as part of restrictive provider networks.

We appreciate the opportunity to share our comments and recommendations with you. Please do not hesitate to contact Chris Lovell at 615 342-0526 (Chris.lovell@dcinc.org) if you would like to discuss them in detail or have any questions.

End of Chris Lovell's Comment

State of Tennessee

Department of Commerce and Insurance

Diana Page,

Company/Organization Not Supplied

1. Ideally vision, hearing and dental could eventually be included for adults.

It is essential to have these services for children.

2. Will insurance companies or other entities work towards quality and accountability for providers?

3. Over-prescription of medications to be addressed? This is a concern for mental health and substance abuse treatment, and likely for other conditions, such as pain management , for instance. Evidence based treatment is very important in these areas in my opinion. (Refer to the recent scandal involving GlaxoSmith Kline--this is likely only a small portion of the misuse of non-addictive prescription drugs). (See "The Anatomy of an Epidemic" by Robert Whitaker as food for thought re: psychotropic use)

4. Ensure quality diagnoses to the extent possible, especially for "soft" diagnoses?

End of Diana Page's Comment

State of Tennessee

Department of Commerce and Insurance

Jim Moore, CEO,

The Cumberland Heights Foundation

Health Care Reform Involves 2 important laws. The main piece of legislation is "The Patient Protection and Affordable Care Act" (otherwise known as "ObamaCare"). The other law is "The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (otherwise known as "Parity"). These 2 laws, while separate and distinct from each other, operate together to provide needed care for people, who prior to Health Care Reform, were unable to obtain treatment for the disease of alcohol and drug addiction. They could not get the treatment because, for one reason or another, they were without insurance.

In January of 2013 the Federal Government will review each state's plan to offer Insurance to those who do not have it. This "Readiness Review" will examine, among other things, the adequacy of the services being offered, not only for medical and surgical needs, but also treatment for "substance use disorders" (otherwise known as drug and alcohol rehabilitation). At that time, Tennessee and the other 49 states will need to demonstrate the satisfactory operation of a "Health Insurance Exchange" in their respective states. Those Exchanges must offer Insurance Plans that provide for essential health services (otherwise known as "Essential Health Benefits"). Tennessee has chosen to develop their own Exchange and Essential Health Benefits package and the Department of Commerce and Insurance houses the team who will do this. Critical hearings are occurring this summer to determine what plan they will recommend to Governor Haslam this fall.

It is the position of the Cumberland Heights Foundation that the Essential Health Benefits should include the full range of treatment services available for the care of those who suffer from the disease of alcoholism and drug addiction. This means that patients who would otherwise not receive treatment will be cared for with a full "continuum of care" that begins with prevention, screening and assessment, and covers all levels of care necessary to address the patients' needs, ranging from acute hospitalization services to residential rehabilitation as well as partial hospitalization, intensive outpatient, traditional outpatient services, and ongoing aftercare and case management services. In other words, those who suffer from the disease of alcoholism and addiction should have the same continuum of care afforded to other people with comparable medical needs resulting from acute and/or chronic disease states. That kind of coverage would be in keeping with the parity requirements of Health Care Reform.

It is further our position that the voices of those associated with the addiction treatment and recovery communities need to be heard. This includes former and current patients and families, providers and referring professionals, and other interested stakeholders. We encourage active participation in these hearings and plan to take an active role ourselves. Together we can positively impact the changes for recovery that will impact 640,000 Tennesseans with the disease of alcoholism and addiction, as well as the 2,560,000 family members who must contend with the devastating consequences of this disease. This is the crucial spirit of the Parity act -- to remove the discriminations in the care of people with mental health and addiction illnesses so that they receive the same care as those with physical illnesses. Recovery can happen!

End of Jim Moore, CEO's Comment

State of Tennessee

Department of Commerce and Insurance

Joseph Rhymer,

Company/Organization Not Supplied

On behalf of more than 19,000 Tennesseans who are living with HIV and AIDS and countless others that are affected, I urge you to ensure that the Essential Health Benefits (EHB) benchmark for the health insurance exchange established under the Patient Protection and Affordable Care Act guarantees adequate coverage for people living with HIV and AIDS and other vulnerable populations.

This should include the following services:

- A prescription drug formulary that supports the current standard of care for people living with HIV is critical. This standard prescribes a minimum of three antiretroviral drugs to effectively suppress the virus. Thus, plans that cover only one or even a few drugs in each category or class covered by the benchmark would not support the current standard of HIV care. Explicit provisions, such as those provided by for the six “protected” classes on the Medicare Part D drug program, are necessary. The formulary should also include medications to treat side effects and other co-occurring conditions like viral hepatitis.*
- Access to HIV experts, including those trained in infectious diseases, without excessive restrictions, for instance through repeated preauthorization or high co-payments for specialty care.*
- Access to the range of services effective for treating mental illness and substance abuse disorders to prevent inpatient hospitalizations and to support people living with HIV and AIDS in adhering successfully to prescribed care and treatment.*
- Coverage of laboratory tests every three to six months to assess an individual’s response to HIV therapies as well as the development of co-occurring conditions as a result of treatment or disease progression.*
- Case management, which helps those living with HIV and AIDS access services to stay healthy and reduce the use of more intensive and more costly health care services, should be included and defined to include care and services system coordination and navigation, along with HIV/AIDS treatment and care adherence counseling, education and support, both in and outside medical settings.*
- Preventative services, including sexually transmitted infections screening and counseling, FDA-approved contraception and contraceptive counseling, and domestic violence screening and counseling, as well as annual HIV screening and counseling.*

The EHB benchmark should prohibit insurance companies from limiting access to medically necessary health care services through dollar or visit limits on essential services, condition-specific restrictions, excessive cost-sharing, and/or unduly burdensome utilization management and prior authorization requirements.

I sincerely appreciate the opportunity to comment on the Essential Health Benefits Plans under consideration by the department and look forward to working towards a benchmark that meets the needs of people with HIV/AIDS and other vulnerable populations in Tennessee.

End of Joseph Rhymer’s Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Teresa Schwartz,

Memphis Oral School for the Deaf

As you begin the arduous task of determining Essential Health Benefits for our fellow Tennesseans, I want to bring to your attention the importance of insurance coverage for cochlear implants and hearing aids for children with hearing loss.

Statistics tell us that 3 out of every 1,000 children are born with some form of permanent hearing loss. Ninety-five percent of deaf children are born to hearing parents. This often leaves parents unaware of the educational, social and psychological impact of hearing loss, and unprepared to make decisions related to communication choices. Most parents want their deaf child to develop listening and spoken language skills ... which is possible if they are fitted with an appropriate listening device such as hearing aids or cochlear implants.

Once the child has a device that enables him to hear speech sounds, enrollment in a program such as the Memphis Oral School for the Deaf (MOSD) that supports the development of listening and spoken language skills at the earliest possible age, will insure that the child has the opportunity to develop these skills. Early intervention leading to the development of listening and spoken language skills gives children an opportunity for academic success and independent, productive adult lives.

In fact, a report in the Journal of the American Medical Association concludes that the development of listening and spoken language skills results in dramatic taxpayer savings over the life of a child with hearing loss: "The expected lifetime cost to society for a child with pre-lingual onset of profound deafness exceeds U.S. \$1 million, largely because of special education and reduced work productivity."

One of the MOST IMPORTANT decisions you will make in determining Essential Health Benefits for Tennesseans is deciding to cover the costs associated with cochlear implants/surgery and hearing aids for children. Your decision to cover these devices will give our children the opportunity for success and independence, and save taxpayer dollars!

I am including some success stories of former MOSD students. To see what is possible for children using hearing aids and cochlear implants, please visit our website at www.mosdkids.org and hear what our children have to say!

End of Teresa Schwartz's Comment

State of Tennessee

Department of Commerce and Insurance

Elizabeth J. Clark, PhD, ACSW, MPH, Executive Director

Karen Franklin, LAPSW, Executive Director

(Tennessee Chapter),

National Association of Social Workers

On behalf of the 145,000 members of the National Association of Social Workers (NASW), I am pleased to submit our commentary on the Essential Health Benefits (EHB) package.

The National Association of Social Workers (NASW) — the largest membership organization of professional social workers in the country — works to enhance the professional growth and development of its members, to create and maintain standards for the profession, and to advance sound social policies. NASW is a strong supporter of the Affordable Care Act and we are hopeful that when finalized, the EHB package will set a national standard for high quality, comprehensive and affordable health care coverage for our country. Also, as the IOM recommended in its report Essential health Benefits: Balancing Coverage and Cost, HHS should be guided by a duty to protect the most vulnerable members of society when formulating the final EHB package.

The following are NASW recommendations for critical components to include in the EHB package:

Care Coordination and Case Management

Comprehensive care coordination and case management should be included in the EHB package. We know that in the absence of these services, individuals are at increased risk for declines in health and functioning, unnecessary health care costs, and needless suffering. Effective care coordination and case management must address not only communication among primary care providers and physician specialists, but also access to chronic disease management (e.g., HIV/AIDS), as well as meeting the psychosocial needs of beneficiaries and family caregivers.

Treatment of Mental Health and Substance Use Disorders Including Behavioral Health Treatment

Appropriate mental health and substance use disorder services will decrease costs in the medical system and lengthen the lifespan of millions of Americans with these illnesses. NASW strongly support the requirement that all plans provide cost-sharing parity for mental health and substance abuse services within benefit categories. Similar to Medicare Part B, exchange beneficiaries needing mental health, substance use and or behavioral health treatment, should be able to receive such services from licensed clinical social workers. Specific benefits should include:

- *Assessment*
- *Outpatient treatment, including both regular and intensive (i.e. partial hospitalization)*

services

- *Residential and Inpatient Services*
- *All FDA approved prescription drugs for mental illness, alcohol, drug and tobacco*

treatment

- *Access to all affordable prescription drugs for HIV or AIDS, without quantity limits, excessive cost sharing or specialty tiers*

- *Emergency Services*

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

- *Laboratory Services*

Rehabilitative and Habilitative Services and Devices

With the inclusion in the Affordable Care Act of the category of rehabilitative and habilitative services and devices, Congress recognized the importance of these benefits to improve the health and functioning of individuals with disabilities. The final EHB package should explicitly establish appropriate coverage of these benefits in a manner that is consistent with the intent of the statute and the needs of people with disabilities and other conditions who require habilitation services and devices.

Reproductive Health Services

The EHB should include the full range of reproductive health services and supplies, including prescription contraception and comprehensive prenatal care.

Hospice and Palliative Care

The EHB should include, at a minimum, all services available to individuals and families dealing with life-limiting illness under the Medicare Hospice Benefit. Such services include, but are not limited to, home care aide, nurse, and physician services; bereavement counseling; medical equipment and supplies; medication and short-term inpatient care for management of pain and other symptoms related to the hospice diagnosis; short-term respite care for family caregivers; and social work services, which should be provided by an individual with a baccalaureate or master's degree in social work. Palliative care services for individuals at earlier stages of serious illness, even from the time of diagnosis, should also be included in the EHB.

Including the above benefits in the final EHB package maintains an appropriate balance of comprehensiveness and affordability. We appreciate your consideration of our recommendations and we look forward to serving as a resource to HHS as it moves forward with this important initiative.

End of Elizabeth J. Clark, PhD, ACSW, MPH, Executive Director

Karen Franklin, LAPSW, Executive Director

(Tennessee Chapter)'s Comment

State of Tennessee

Department of Commerce and Insurance

Margaret Frazier

Administrative Secretary to President/CEO Robert P. Main, FACHE,

Siskin Hospital for Physical Rehabilitation

Thank you for the opportunity to provide comments regarding the essential health benefits package for health insurance coverage under the Affordable Care Act (ACA). Further, I appreciate your invitation to advise the Commerce and Insurance Commissioner about which of the ten potential benchmark plans designated by the United States Department of Health and Human Services (HHS) should be selected by Tennessee as a benchmark or reference plan.

The ACA ensures that patients will have access to medical rehabilitative services as an essential benefit by requiring inclusion of rehabilitative and habilitative care as one of the ten categories of benefits. Rehabilitative care is designed to reduce physical or mental disability and/or restore the patient to his or her best possible functional level, while habilitative services help individuals acquire the skills necessary to perform activities of daily living. Essential benefits are to include rehabilitative and habilitative care to ensure comprehensive care that is consistent with the goals of the essential benefits package. For example, if a person has a major health care event such as a traumatic brain injury, a stroke, or a spinal cord injury, essential benefits would include emergency care, hospitalization, physician services, and pharmaceuticals to address the immediate medical conditions. But essential benefits must also include rehabilitative and habilitative care, including psychological and behavioral services, to restore as much functional ability as possible at the appropriate level of intensity and within a reasonable timeframe. The essential benefits package was designed to ensure that patients have the services they need when a health care condition arises. Without rehabilitative and habilitative care, patients will be at risk of being without coverage at a time when they need it most. Such a result is inconsistent with the goals of the essential health benefits package, and the broader goals of health care reform.

Tennessee must select a benchmark or reference plan that defines the benefits package to apply to the post-acute care setting, not simply acute care. Post-acute care services consist of such necessary services as:

Comprehensive rehabilitation services and medical management prescribed by a physician, in coordination with a team of rehabilitation professionals, and designed to maximize functional ability and return to the greatest level possible of independent living and community participation post-injury or illness;

Habilitation therapies such as physical, occupational and speech therapies or other treatments that enable a person with a disability (e.g., a child with cerebral palsy) to attain and retain functional abilities not acquired since birth;

Outpatient rehabilitation services such as physical, occupational and speech therapy, as well as other services that improve, maintain, and prevent deterioration of function after an illness, injury, or disability;

Durable medical equipment, prosthetics, orthotics, supplies (DMEPOS), mobility equipment, assistive and adaptive devices that improve or maintain function and do not include arbitrary limits on access to these devices and related services; and

Rehabilitation interventions that are reasonable and necessary and, when possible, evidence based. In the absence of level I evidence, other levels of medical evidence should be fully considered when determining the value and efficacy of specific rehabilitation options.

Because of the importance of rehabilitative and habilitative services to individuals with chronic conditions and disabilities, comprehensive coverage of these services is essential. Comprehensive coverage includes coverage of services provided in various sites of care, including Inpatient Rehabilitation Hospitals/Units (IRH/Us), Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Skilled Nursing Facilities (SNFs). It also includes outpatient therapies such as physical

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

therapy, occupational therapy, and speech language pathology. Finally, comprehensive coverage should include necessary durable medical equipment including manual and power wheelchairs, orthotics and prosthetics, and other devices.

Federal health care programs may serve as a model when determining covered benefits. The Medicare program, the Veterans Health Benefits program, the Department of Defense health program, many Medicaid programs, and the standard option under the Federal Employee Health Benefits Program (FEHBP) all cover significant rehabilitation and habilitation services relevant to people with disabilities and chronic conditions. These plans could be considered as models in selecting a benchmark or reference plan for Tennessee.

A fair balance must be struck among the ten categories of essential care, based on medical necessity, and reflecting patient needs and access considerations. Unfortunately, under many insurance plans, rehabilitative and habilitative services and devices are either not covered or there may be significant limits on coverage. Adequate access to these services is critically important because such rehabilitative services have profound implications for people's ability to live independently. They speed recovery, improve long-term functional ability, health status and quality of life, reduce readmissions and halt the progression of primary and secondary disabilities. An appropriately balanced category, looking at the rehabilitation services component, would include all relevant rehabilitative therapies and other treatments in appropriate settings and intensity that improve, maintain and prevent deterioration of function, which includes improving quality of life.

In an effort to determine what constitutes such a plan, the U.S. Department of Labor (DoL) issued a report in April 2011, which includes an analysis of what constitutes a "typical employer plan" for purposes of gauging which benefits should be included in the EHB package. The report is titled, "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," and was mandated by the ACA. The national trade association representing medical rehabilitation providers, the American Medical Rehabilitation Providers Association (AMRPA), analyzed this report and finds it incomplete on a number of significant issues.

Specifically, the survey limits its discussion of rehabilitative services to physical therapy services. However, rehabilitative services incorporate a number of types of therapies including occupational therapy services and speech-language pathology services. Alarming, the report states that coverage of rehabilitative services in inpatient rehabilitation hospitals and units is outside the scope of the survey. Failure to capture the provision and coverage of rehabilitative services in all settings of care limits the report's credibility to demonstrate the true nature of coverage for these services. Habilitative services, while included with rehabilitative services as one of the 10 categories of EHBs, are not discussed at all in the report further limiting the report's accuracy and effectiveness.

AMRPA conducted its own survey of its members to assess rehabilitation hospitals' and units' experience with coverage of "rehabilitative and habilitative services and devices." The overall findings of its study demonstrate that the typical employer plan (TEP) provides a significant degree of coverage for medical rehabilitation services and devices. A summary of the study's findings follow:

Nearly all insurers that AMRPA members work with cover services provided in the rehabilitation hospital and unit setting. Preauthorization is typically required and the beneficiary typically bears some financial responsibility for the costs associated with inpatient rehabilitation services;

Survey participants found that the vast majority of private plans cover outpatient rehabilitation services with some cost-sharing required by the enrollee; and

State of Tennessee

Department of Commerce and Insurance

Most health plans cover durable medical equipment, orthotics and prosthetics, though some place certain restrictions on coverage for repair or replacement of such devices.

Medical rehabilitation is a critical component of the health care system. It prevents unnecessary medical costs over the long-term and discharges patients with disabling conditions back to their homes and community. We appreciate your commitment to patients and health care reform and look forward to working with you.

End of Margaret Frazier

Administrative Secretary to President/CEO Robert P. Main, FACHE's Comment

State of Tennessee

Department of Commerce and Insurance

David Buckman, M.D., FACEP, FAAFP,

Company/Organization Not Supplied

To Whom it May Concern:

I am writing to request your help in seeing that certain items are included in the "Essential Health Benefits" package as of full implementation of Affordable Care Act in 2014 in our state. There are two areas that are "dear to my heart" as a father of an adult offspring with Autism Spectrum Disorder (my 34 year old daughter Jeanne Marie has Asperger's Syndrome) and the grandfather of a 5 year old (Marcus who is profoundly hearing impaired) effected by congenital near-deafness. I won't burden you with all of the details of these personal stories, but suffice it to say I have experienced up close and personal the help or lack of it in services to those with Autism and Congenital Deafness in our state.

Jeanne continues to struggle in adjusting to adult life, finding an employment niche she can sustain, transitioning to a degree of independent living, as well as developing a healthy social network. There are few resources in our state to assist in these challenging areas for adults with Autism. Transitional housing, life coaches, employment assistance/coaches, case workers, life skills resources, the list goes on. Please consider including at a minimum transitional housing subsidy/assistance, life skills services, and transitional employment services for individuals with Autism (especially ADULTS with autism). Right now they are pretty much "on their own" sink or swim in our state. As family we are doing out best to help her "swim" but the going is pretty rough on our own.

Marcus has been fortunate enough to have his hearing impairment recognized shortly after birth, and has had hearing aids since approximately 2 months of age. Though he was behind in terms of language development, thanks to Vanderbilt Bill Wilkerson center and state assistance with hearing services, hearing aids, and subsidy to help him attend the Mama Lere school at Vanderbilt, as of this summer he is actually testing appropriate for his peer group of non-hearing-impaired peers. Praise the Lord! None of this would have been possible had he not had the benefit of basic hearing assist devices and services. Please be sure that hearing aids and hearing services are included for our kids (at least). If we don't give them a shot at normal language and communication development in infancy and childhood we will be paying for their dependence for years to come which would be far more expensive in every way.

End of David Buckman, M.D., FACEP, FAAFP's Comment

State of Tennessee

Department of Commerce and Insurance

Scott R. Farnen, J.D., CLU®

Manager, Group Compliance,

Ameritas Life Insurance Corp.

services: 1) balancing cost and coverage, 2) metal level

requirements, 3) how these services are authorized in the exchanges, and 4) the need for equitable treatment for pediatric oral health services outside of the exchanges.

Balancing Cost and Coverage for Pediatric Oral Services

First, Ameritas recommends reviewing the full benefit package of small employer groups, specifically those that include separate dental policies. Currently, 98% of dental policies are purchased separately from medical policies. When dental benefits are offered in the small employer market, premiums are often paid for entirely by the employees themselves. Plan designs often include Basic, Restorative and Major categories of dental care, at 100%, 80% and 50% coinsurance levels. Orthodontics is typically not offered in this market.

As you may be aware, the Essential Health Benefits Bulletin released on December 16, 2011 included four health benchmarks from which states could chose to base their benefit structure to meet the EHB requirements of the ACA. The Bulletin provided alternatives when those benchmarks do not include all ten categories of EHB. For pediatric oral health services, two specific options were the Federal Employee Dental and Vision Program (FEDVIP) and the state's Childrens Health Insurance Program (CHIP). Neither of these are considered typical small employer plans.

Therefore, Ameritas recommends utilizing the small employer model for the pediatric oral health services EHB benchmark. Although many dental policies cover similar clinical procedures, costs vary greatly due to the level of cost sharing and cost containment features. Tennessee will need to balance the key components of coverage and affordability; a small employer model benchmark helps strike equilibrium between the two. The attachment, "Issue Brief: EHB Dental Benchmarks" was created by our dental trade association, the National Association of Dental Plans (NADP). It may assist your agency further on how to achieve balance of coverage and affordability for the pediatric oral health services portion of the EHBs.

Benefit Design Standards

Ameritas believes that the metal level requirements for dental and vision should be considered with

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

objectives of simplicity and clarity in view of the limited nature of these benefits and their limited impact on the overall Qualified Health Plan (QHP) package they may be coupled with. Currently they are not separately identified on the Actuarial Value (AV) calculators. The National Association of Dental Plans, of which Ameritas is a member, is planning to contact CCIIO staff regarding the need for guidance to states on this topic. The hope is to ensure that the actuarial value calculation is always applied separately to dental, whether sold as standalone, or embedded in a QHP, and that requiring essential pediatric oral services to meet any AV level below gold (80%) would require the application of cost sharing to diagnostic and preventive services. Such cost sharing isn't typical of small group or individual dental plans, and also runs counter to the ACA prohibition on cost sharing for preventive services.

Pediatric Oral Services within the Exchanges

Second, the HHS Exchange final rule clarifies and codifies (§ 155.1065) the requirement that stand-alone dental plans be offered through the Exchange. Stand-alone dental plans may be offered separately or in conjunction with a medical plan, as long as the dental plans offer at least the pediatric oral health services essential benefit.

We ask the Tennessee Department of Commerce and Insurance to review implications and plan accordingly when building your exchange to ensure consumers have broad access to all dental plans offering the required benefits and meeting qualification standards inside the exchanges.

Pediatric Oral Services for Population Outside of the Exchanges

Lastly, although the ACA explicitly allows stand-alone dental policies to satisfy the pediatric oral health EHB requirement in the Exchanges, it does not do this outside of the Exchanges. As the EHB requirements are applicable to all individual and small group plans in and outside the Exchange, dental plan benefits provided by stand-alone dental plans outside the Exchange will provide duplicate pediatric benefits to what a health plan must offer.

Today, 98% of dental policies are purchased separately from a medical policy. We need Tennessee to consider providing waivers for medical policies so they are not required to include the pediatric oral services in their policies if separate dental policies are authorized and qualified to do so already. If medical plans are required to cover the pediatric oral services outside the exchanges, there is potential for additional and unnecessary costs for dual coverage of these services, and a reduction in the number adults that may enroll in a dental plan if their children have some coverage for services under a medical

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

plan.

We would be happy to discuss any of the above items in further detail if needed.

End of Scott R. Farman, J.D., CLU®

Manager, Group Compliance's Comment

State of Tennessee

Department of Commerce and Insurance

Virginia Trotter Betts, MSN, JD, RN, FAAN,

Primary Care & Public Health Department

The University of Tennessee Health Science Center

I regret that I will be unable to attend the Memphis public hearing on the SHIE benefit plan options, but I want to voice my strong expectation that TN include mental and substance use disorders among its covered disease categories and provide parity for their treatment services. As I am sure you are aware, the incidence of mh/sa disorders is extremely high---when blended together, 37% of all Tennesseans may need mh/sa services annually. Attention to coverage and care of these sometimes complex but fundamental disorders is essential to improved health outcomes in Tennessee.

To be specific, I suggest that the TN SHIE benefit package include:

- (1) the same set of mental health and substance abuse benefits as is currently available in the TNCare program.*
- (2) Psychiatric crisis response should be required in the health insurance exchange benefit on par with emergency response services for other domains of care.*
- (3) If the TNCare service array/package is not chosen, another option would be to adopt the same benefit package as the Federal Employee Benefits Plan, Standard Option. (The Federal Employee Benefits Plans had been subject to parity requirements since 2001 and have a long track record of effectiveness in terms of care outcomes and cost effectiveness.)*
- (4) For prescription drug benefits, the Medicare Part D model includes all or substantially all anti-psychotic and anti-depressant medications in the Preferred Drug List and should be the TN model including allowing off-label use of medications which can be an important part of providing affordable psychiatric care.*
- (5) Prevention, screening, and early care services for mh/sa disorders in all settings for all ages---especially for children and adolescents.*

Your consideration of these services in TN's future insurance coverage through the SHIE is very much appreciated. Coverage of the range of quality services as described above and delivered by expert clinicians—advanced practice nurses, doctors, social workers, and psychologists—is an important step the Department of Commerce and Insurance can ensure for our state.

Please feel free to contact me if I can be of any assistance to you or your staff in your deliberations.

End of Virginia Trotter Betts, MSN, JD, RN, FAAN's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Madeline Garr,

Company/Organization Not Supplied

I am writing as a longtime advocate for affordable access to health care, as a mother, as a former employee of Vanderbilt University, as a retired person, and as a native born Tennessean. I ask that Tennessee be in the forefront in offering Gold standard benefits to all Tennesseans who qualify for the Exchange. This will put our state in the position of being a leader in the nation rather than one which lags behind. With hospitals such as Vanderbilt Medical Center, Children's Hospital, UT Medical Center, etc., it is important for our future to be seen as such a leader and creating a Gold Standard would go a long way in making this happen. I hope as the staff and Commissioner McPeak deliberate on what will be recommended to the Governor that the health and welfare of all Tennesseans will be at the forefront of your recommendations as you serve the State of Tennessee and all of its citizens.

End of Madeline Garr's Comment

State of Tennessee

Department of Commerce and Insurance

C. Gregg Conroy, CEBS, SPHR, CMS, Fellow ISCEBS on behalf of HR Limited,
HR Limited

I was privileged to attend the first of TDCl's state-wide meetings in Nashville and to hear the input from the dozen or so of the attendees who addressed the department's representatives. Each speaker had good cause and intention in suggesting the various conditions, treatments, drugs, etc. that they feel need to be included in the state's definition of "essential health benefits." I am sure there will be others to address both these conditions and others at the remaining meetings around the state. My concern is that, however well intentioned, these individuals and the organizations/interests they represent are looking through a narrow lens of coverage for their cause and are not considering the broader implications of the costs associated with including all of these suggested benefits. As a long time employee benefits and human resources professional I am concerned that they are not considering the critical element of overall affordability as they support their focused interests. If every suggested/requested component is included in "essential health benefits" then both at the individual policy and employer coverage, only the most reduced levels of coverage for each essential health benefit will be affordable.

While it is easy to say yes to each legitimate health concern, it is also a legitimate concern to consider the cost impact of all the "yesses" on both employer provided health benefits and the individual policies that will be available, on the exchanges or otherwise. Affordability must be factored into the state's decisions on what to include in "essential health benefits" or even the "Bronze" level coverage may be out of the reach of those who need it.

Thank you for your consideration.

End of C. Gregg Conroy, CEBS, SPHR, CMS, Fellow ISCEBS on behalf of HR Limited's Comment

State of Tennessee

Department of Commerce and Insurance

Lance T. Laurence, Ph.D.,

Tennessee Psychological Association

Good afternoon. My name is Dr. Lance T. Laurence. I am a Clinical Psychologist, living in Knoxville. I speak to you in my role as Director of Professional Affairs for the Tennessee Psychological Association. My remarks today and the PowerPoint presentation I've sent the Commissioner's office are approved remarks I've been asked to communicate on behalf of the Board of Directors of the Tennessee Psychological Association. The Tennessee Psychological Association is the state-approved affiliate of the American Psychological Association, representing those practicing psychology in Tennessee. All of my remarks today should be considered as expressing the views of the Tennessee Psychological Association on these matters.

The Tennessee Psychological Association thanks the Commissioner and those present for permitting us the opportunity to speak to you on the Essential Health Benefits requirements contained in the Patient Protection & Affordable Care Act. I am here today to speak solely on the mental health and substance use disorders provisions mandated by PPACA. In preparation for today I've already emailed my remarks and a powerpoint presentation on these matters for your prior review. These are highly complex matters and a detailed analysis of the mental health and substance use disorder implications for future State Exchanges requires considerable time to fully understand. Because of this complexity, we prepared for you a PowerPoint presentation which reviews the Medical Cost Offset Effect of Mental Health Services, illustrates the importance of behavioral healthcare providers in promoting good patient outcomes, and summarizes for you the research literature on these matters. In order to permit as many members of the general public to testify today, I will limit my presentation to less than 10 minutes.

It is an accepted fact that treating human beings and promoting health requires an integrated approach that addresses the whole person, both body and mind. 1.5 million people in Tennessee need mental health care, yet only 38% get it. Mental health problems compound major medical conditions such as obesity, high blood pressure, heart disease and cancer. Over 60 billion dollars was spent last year on drug and alcohol problems, and Tennessee remains the #2 state in prescription drug abuse problems. Claims for stress, depression and anxiety cost our employers an estimated \$350 billion each year due to lost productivity, accidents, disability claims and medical fees. Twenty percent of the population will experience a significant depressive episode in their life and 28 Million Americans currently take anti-depressant medication, roughly 10% of our population. Figures such as these are even more staggering when one sees the rise of mental health problems in our children and adolescents, including but not limited to the increase in the suicide rate amongst our young from 15-24.

Laws such as the federal mental health and substance abuse parity act are one response to the need to treat the entire person, mind and both. But more action is needed. Health care costs continue to escalate. The delivery system has become increasingly fragmented. 75% of today's health care costs are for chronic diseases yet our typical approach for treating these disorders does not include efforts which integrate behavioral health and physical health care. These same individuals are often voracious users of already limited medical resources such as emergency room services. 12 million of these ER visits are due to a mental health or substance abuse problem, or 1 in every 8 ER visits. Of these, 40% result in hospitalization. Depression problems account for 43% of these visits, anxiety conditions such as panic disorder 26% and substance abuse another 23%. These frequencies of ER visits occur whether one has private insurance, Medicare, Medicaid or if one is uninsured.

Recent developments in health care reform attempt to address the challenges to the nation's health care system and this public testimony occurs as our State attempts to wrestle with the best way to craft Essential Health Benefit packages for our State Exchanges. Given this challenge, the Tennessee Psychological Association recommends the following

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

parameters for any plan offered in Tennessee or in the State Exchanges as it relates to the mental health and substance use disorder statutory requirements of PPACA:

1. Benefit design for mental health and substance use disorders must adhere to and be consistent with federal law, the Mental Health Parity and Addiction Equity Act (MHPAEA).

- Such compliance with federal law means the lifetime and annual spending limits for physical and behavioral health care are at the same funding levels*
- There is no separate deductible for behavioral health care from a deductible for physical care*
- Behavioral health care providers copayments are in the same category as primary care providers and shall not be considered specialty provider care*
- Except for those plans exempt from the federal parity law (i.e., state employees), plans shall not be permitted to exclude coverage for any particular type of mental health or substance use disorder.*

Mental Health & Substance Use Disorders are #5 in the list of ten Essential Health Benefits contained in the Patient Protection & Affordable Health Care Act therefore, any and all ACO plans, non-grandfathered plans in the individual and small group markets, both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs must include mental health and substance use disorder services.

2. Adherence to T.C.A. 56

All Exchanges, ACOs, and Health Plans should adhere to the statutory requirements currently contained in T.C.A. 56. Such plans should detail how they will adhere to these provisions which protect and preserve access, patient and provider rights, appeals procedures, non-discriminatory practices, and related processes contained in T.C.A. 56.

☐ Specific Adherence to Mental Health Utilization Procedures contained in T.C.A. 56 is critical in the delivery of mental health and substance use disorder services

☐ Medical Necessity and Utilization Review Criteria used by any plan must be published on the plan's website, available to patients and providers upon request, and not considered propriety materials. Such transparency helps promote quality patient care and appropriate use of health care resources

☐ Appeals processes for disputing adverse determinations for patients and providers must be available and easy to employ

☐ Per the Institute of Medicine (2001), evidenced-based practices in mental health and substance use services should be defined as follows: "evidenced based practice is the integration of best research practices with clinical expertise and patient values".

3. Promote collaborative and integrative care between behavioral health and physical health providers.

☐ Cost-offset data indicate the importance of integrated behavioral and medical care for quality care, good patient outcomes, and financial savings. To achieve such results, care needs to be not just collaborative but integrated. To actualize this aim, require behavioral health care providers as full members of any Board of Directors, Executive Board Members, and Advisory Board composition for any plan in the Exchange. Mandate such membership as at least 1 behavioral health provider for every 6 medical providers, knowing that 1:5 or 1:4 or 1:3 membership ratios are more desirable.

State of Tennessee

Department of Commerce and Insurance

☐ *Should the State of Tennessee create an Oversight Committee to monitor and influence the operation of Exchanges in Tennessee, appoint an appropriate number of behavioral health care providers to that committee.*

☐ *require all plans in the Exchange to develop and implement a collaborative and integrated approaches to chronic physical illness. For those with repeat emergency room and hospital visits, collaborative and integrated care involves comprehensive evaluation and treatment that integrates the efforts of BOTH the behavioral health provider and the physical health care provider. For these consumers, consider assigning both a primary care physician and a primary behavioral health care provider*

4. Eliminate archaic billing procedures

☐ *Eliminate those payment procedures that forbid billing behavioral health and physical health for services rendered on the same day. Such practices promote fragmented care, not integrated care*

☐ *Require all plans and exchanges to reimburse the CPT behavioral health codes at usual and customary levels of reimbursement*

5. Continuing Education Requirements on Treating the Whole Person

☐ *Movement toward integrated care will result in better patient outcomes and reduced cost BUT it will require a major “relearning” task for patients, providers, and administrative systems of care. To help promote this movement toward integrated care, consider requiring all plans in the Exchange to require annual integrative care continuing education (i.e., integrative care efforts for treating chronic ER users; workshops on the role of treating depression for improving medical conditions –diabetes, hypertension, cardiac, others)*

Thank you for this opportunity to speak to you on these most important matters.

End of Lance T. Laurence, Ph.D.'s Comment

State of Tennessee

Department of Commerce and Insurance

Sarah H. Hicks,

Company/Organization Not Supplied

State Plans meetings on essential health benefits. Citizens' input being sought. Thank you -- We need to insurance everyone.

End of Sarah H. Hicks's Comment

State of Tennessee

Department of Commerce and Insurance

Rev. Don Beisswenger,

Company/Organization Not Supplied

I trust our leaders will include Tennessee in the health care options in the new affordable care act. We need it.

End of Rev. Don Beisswenger's Comment

State of Tennessee

Department of Commerce and Insurance

[Name redacted because of personal health information included.],

Company/Organization Not Supplied

I have been working with many physical illnesses – including Sjogren’s Syndrome – only due to not being able to afford health care. Myself and my doctors feel that I should sign up for my disability, but I can't – due to no health care coverage. And I will be 60 this month, working all my adult life with sickness that is only getting worse. I have over 15 diagnoses: RA/OA, IBS, LPR, diabetes, hypertension and many, many more. No one would insure me with these inflammatory diseases, and it's a shame that I have to push so hard and make myself worse as stress increases all my illnesses. I'm an adult case manager in behavioral health now for 25 years.

End of [Name redacted because of personal health information included.]’s Comment

State of Tennessee

Department of Commerce and Insurance

Mike and Willie Wood,

Company/Organization Not Supplied

Suggestions For Health Insurance Policies Issued Through New Exchanges

1 - Guaranteed issue with no consideration of medical history and with immediate coverage for pre-existing conditions.

2 - Broad major medical coverage with no policy limits and no deductibles or co-pays for preventive medical care.

End of Mike and Willie Wood's Comment

State of Tennessee

Department of Commerce and Insurance

Name Not Supplied,

Company/Organization Not Supplied

I think that this is a good c thiause [sic], and would like to receive emails concerning this project.

End of Name Not Supplied's Comment

State of Tennessee

Department of Commerce and Insurance

Name Not Supplied,

Company/Organization Not Supplied

Reading the article in the Chattanooga Times, I want to support Dr. B.W. Ruffner's recommendation for a health plan that offers affordable prescription and mental health services and treatment.

Preventive care is extremely important to decrease health problems facing our country. Obesity has been the most targeted. However, we tend to overlook the much-needed mental health aspect in health care. If one's mental health is affected, it causes problems with one's physical health. A woman I know was diagnosed with anxiety disorder, six years ago. The places she worked in the past did not offer health care insurance. Her private insurance plan does not provide for mental health care such as counseling. At present, she is unemployed and needs to be in a counseling program. The woman applied to the county mental health department but even then it will cost \$35 an hour. According to an advertisement, one out of every four Americans is in need of mental health treatment. The cost to the government for the untreated is about \$100 billion a year. The problems these individuals exhibit lead to incarceration in jails, suicides, felony acts, killings and more. Any health program considered should offer mental health treatment

End of Name Not Supplied's Comment

State of Tennessee

Department of Commerce and Insurance

Melanie Bacon, Director,

TN Hands & Voices

I am the parent of a four-year-old daughter with severe to profound bilateral hearing loss. My husband and I wanted our daughter to have access to sound, to hear us and to be able to communicate with us either by spoken language or American Sign Language. We were fortunate enough to have help in obtaining hearing aids for our daughter when she was only 7 months old. Her hearing aids bring her up to a level almost equal to that of a hearing child. She is now functioning right along with her hearing peers with no speech delays at this time. If we had been unable to obtain hearing aids for her, she would not be functioning at the level she is today, she would not be ready to start mainstream kindergarten next year!

I am also the Director of TN Hands & Voices, a statewide, non-profit, parent-driven organization dedicated to supporting families of children who are deaf or hard of hearing. We are unbiased towards communication modes and methods and believe families can make the best choices for their child if they have access to good information and support. Our diverse membership includes those who are deaf and hard of hearing and their families who communicate manually and/or orally. From American Sign Language to cochlear implants, our organization represents people from all different approaches to, and experiences with, deafness or hearing loss. We exist to help our children reach their highest potential.

Families of deaf and hard-of-hearing children should have access to all information and resources so that that they are able to make an educated choice for their child. These children should have access to affordable hearing aids and/or cochlear implants at an early age, if this is the best choice for them. Many children with hearing loss, if given hearing technology, can learn to listen and speak. This in turn can decrease costs later in special education.

When determining Essential Health Benefits for our state, please keep our children born with hearing loss at the forefront of your minds and uphold the hearing aid mandate for children 0-18 passed in 2011.

End of Melanie Bacon, Director's Comment

State of Tennessee

Department of Commerce and Insurance

Molly Mann,

Company/Organization Not Supplied

I'd like to buy the same health insurance for myself, that I buy for the Tennessee Legislators and Governor. I should pay the whole premium price, not just the employee price.

I would love to go to one of those Health Care Meetings/Hearings.

End of Molly Mann's Comment

State of Tennessee

Department of Commerce and Insurance

Didi Foster,

Company/Organization Not Supplied

I know you are in the process of conducting outreach meetings across the state to gather input from Tennesseans about the health conditions that should be covered under essential health benefit categories. I have lived in Tennessee for 2 ½ years now and plan to stay. I am writing because affordable health care is important to me. Unfortunately, due to the expense for small companies and health care in general, many smaller companies do not offer even the ability to purchase insurance. I have also been self-employed as a contractor for the large corporation that I used to work for (10 years, since 2002, off and on). Of the people 6 people I worked with in company, 3 are contract workers, 1 works as a graphic designer for other companies, 1 still works for the company and two have retired. My point is that only 1 of these 6 people is eligible for insurance benefits. I purchase my own insurance and have done so since 2002. As people approach 50 years of age, they can expect their insurance premiums to increase. I also lost my contract with the company in 2008. Now, I subcontract for a friend when they need extra help, so I can no longer afford to pay that amount. Because I still own a condo, I buy insurance with a high (\$5,000) deductible, in case I get in an accident or get sick. It costs me \$168/month and does allow a physical and a Well Woman visit each year.

I don't know why people would oppose affordable health care. I recently spoke to a man who was insured through his work but didn't insure his wife because the cost was about \$1,200 a month. Her work doesn't have insurance and now they think she has cancer.

I have worked since I was 17 years old. Sometimes I had insurance available; sometimes I didn't. I strongly feel like, if someone is working, they should have affordable insurance.

I recognize there needs to be personal responsibility, but I also think that we need to be able to purchase health care at a reasonable cost.

I also think that people need to be educated and perhaps get a lower rate if they stay within a healthy weight range, etc., or at least not be penalized too much for getting older as that is inevitable. However, poor health, more likely in older people, but not inevitable, is also related to diet and lack of exercise. Hence education and counseling (weekly meetings/exercise as part of care with groups of patients) on diet and exercise as part of the treatment for illness such as type-2 diabetes should be strongly encouraged.

Those are my thoughts. I strongly feel that all people in the U.S. should have access to basic health care.

End of Didi Foster's Comment

State of Tennessee

Department of Commerce and Insurance

Karen Diana, APN

Psychiatric Mental Health Nurse Practitioner,

Chamberlin Clinic, PA

I think it is imperative that mental health care coverage be mandatory and covered for all through private and public insurance plans. Mental Health Care is a medical problem.

I have many patients with bipolar disorder who are on very expensive medications. These are working individuals with private health care coverage, but because their insurance plans have carved out their benefits to another company and forced them to pay different deductibles, they cannot afford their medications.

Please give people affordable and fair coverage for mental health.

End of Karen Diana, APN

Psychiatric Mental Health Nurse Practitioner

's Comment

State of Tennessee

Department of Commerce and Insurance

B W. Ruffner,

Tennessee Medical Association

First, let me thank you for the opportunity to share TMA's perspective and for keeping us informed.

I am sure that the Tennessee Essential Health Benefits grid required many days of work. It is an invaluable resource for comparing plans and for reflection about services that should be considered, and also identifying State mandates. Thank you for sharing it with us.

Rather than addressing specific issues in the 10 categories of essential services, we will focus on some general principles, after a few thoughts about prescriptions drugs.

Your comparison chart reveals that for the United HMO and the small group plans, prescriptions are covered by riders in each option. Your chart also indicates that non-preferred and specialty drugs require precertification in the Federal Plans. This means that access to medicines is not well defined in these possible benchmarks. Patients' access to appropriate pharmaceuticals is essential for adequate care. At a minimum, we request that allowed drugs will match or exceed those available for TennCare patients: 2 prescription drugs and 3 generics per month. In addition, TennCare patients have access to a fairly long additional list of drugs, mainly for generics used in combination for chronic diseases that do not count against the limit.

Our other thoughts are more general. First, we believe that it will be critical for patients to be able to know that their providers are participating in the insurance plan that they are considering. The State will be building an Internet website to help patients make their choices. The website should include up-to-date information about hospitals and physicians who are participating in each plan and whether the physicians are accepting new patients. It is equally important that in-network specialist physicians also be listed online.

Second, as actuaries are struggling with requirements to keep within the 60%, 70%, 80%, and 90% estimated benefits costs for bronze through platinum plans, they may reduce the actuarial value of the less generous plans by limiting services for home health, skilled nursing, medical rehab or behavioral health services. We believe that even bronze plans' limitations should be no less that [sic] those specified in the benchmark plan that you [choose].

The TMA is committed to enhancing the health of all Tennesseans. Insurance exchanges, if will [sic] designed, well implemented and well monitored will enhance the welfare of many citizens by opening new options for insurance for those employees in small businesses and by making available affordable, more comprehensive insurance for individuals.

We particularly appreciate the effort that your department and the Department of Finance have made to keep us informed, and your receptivity to our thoughts. Thanks for listening.

End of B W. Ruffner's Comment

State of Tennessee

Department of Commerce and Insurance

Audrey Kalbach MSN, APRN,
Family and Psychiatric Practice

These are the suggestions of Virginia Trotter Betz MSN,JD and I totally agree with these suggestions. Good Mental Health Care is imperative with an emphasis on prevention, public education of recognition of signs and symptoms, and screening for early care, which is so evident with all of the recent violent social issues occurring..

Audrey Kalbach MSN, APRN
Family and Psychiatric Practice

To be specific, I suggest that the TN SHIE benefit package include:

- (1) the same set of mental health and substance abuse benefits as is currently available in the TNCare program.*
- (2) Psychiatric crisis response should be required in the health insurance exchange benefit on par with emergency response services for other domains of care.*
- (3) If the TNCare service array/package is not chosen, another option would be to adopt the same benefit package as the Federal Employee Benefits Plan, Standard Option. (The Federal Employee Benefits Plans had been subject to parity requirements since 2001 and have a long track record of effectiveness in terms of care outcomes and cost effectiveness.)*
- (4) For prescription drug benefits, the Medicare Part D model includes all or substantially all anti-psychotic and anti-depressant medications in the Preferred Drug List and should be the TN model including allowing off-label use of medications which can be an important part of providing affordable psychiatric care.*
- (5) Prevention, screening, and early care services for mh/sa disorders in all settings for all ages---especially for children and adolescents.*

Your consideration of these services in TN's future insurance coverage through the SHIE is very much appreciated. Coverage of the range of quality services as described above and delivered by expert clinicians—advanced practice nurses, doctors, social workers, and psychologists—is an important step the Department of Commerce and Insurance can ensure for our state.

Please feel free to contact me if I can be of any assistance to you or your staff in your deliberations.

End of Audrey Kalbach MSN, APRN's Comment

State of Tennessee

Department of Commerce and Insurance

David M. Yoder ,

Health Insurance NOW LLC

The establishment of a health exchange is essential to the lives of many Tennesseans. In order to offer a cost-effective and sustainable minimum plan with solid benefits, I would like to suggest the following:

- *Prescription coverage with no deductible and low copays for generics*
- *Prescription coverage with a deductible for brand drugs*
- *Copays for office visits for Primary and Specialist*
- *High Emergency Room copay that is waived with a hospital admission*
- *Low hospital deductible with a 30% co-insurance after deductible*

End of David M. Yoder

's Comment

State of Tennessee

Department of Commerce and Insurance

Larry Frampton,

Company/Organization Not Supplied

On behalf of more than 19,000 Tennesseans who are living with HIV and AIDS and countless others that are affected, I urge you to ensure that the Essential Health Benefits (EHB) benchmark for the health insurance exchange established under the Patient Protection and Affordable Care Act guarantees adequate coverage for people living with HIV and AIDS and other vulnerable populations.

This should include the following services:

- A prescription drug formulary that supports the current standard of care for people living with HIV is critical. This standard prescribes a minimum of three antiretroviral drugs to effectively suppress the virus. Thus, plans that cover only one or even a few drugs in each category or class covered by the benchmark would not support the current standard of HIV care. Explicit provisions, such as those provided by for the six “protected” classes on the Medicare Part D drug program, are necessary. The formulary should also include medications to treat side effects and other co-occurring conditions like viral hepatitis.*
- Access to HIV experts, including those trained in infectious diseases, without excessive restrictions, for instance through repeated preauthorization or high co-payments for specialty care.*
- Access to the range of services effective for treating mental illness and substance abuse disorders to prevent inpatient hospitalizations and to support people living with HIV and AIDS in adhering successfully to prescribed care and treatment.*
- Coverage of laboratory tests every three to six months to assess an individual’s response to HIV therapies as well as the development of co-occurring conditions as a result of treatment or disease progression.*
- Case management, which helps those living with HIV and AIDS access services to stay healthy and reduce the use of more intensive and more costly health care services, should be included and defined to include care and services system coordination and navigation, along with HIV/AIDS treatment and care adherence counseling, education and support, both in and outside medical settings.*
- Preventative services, including sexually transmitted infections screening and counseling, FDA-approved contraception and contraceptive counseling, and domestic violence screening and counseling, as well as annual HIV screening and counseling.*
- The EHB benchmark should prohibit insurance companies from limiting access to medically necessary health care services through dollar or visit limits on essential services, condition-specific restrictions, excessive cost-sharing, and/or unduly burdensome utilization management and prior authorization requirements.*

I sincerely appreciate the opportunity to comment on the Essential Health Benefits Plans under consideration by the department and look forward to working towards a benchmark that meets the needs of people with HIV/AIDS and other vulnerable populations in Tennessee.

End of Larry Frampton’s Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Noma B. Anderson, Ph.D., Dean,
College of Allied Health Sciences

University of Tennessee Health Science Center

Thank you for holding one of the public meetings at UTHSC. I want to submit comments regarding the importance for health care insurance benefits including rehabilitation services and an extended period of coverage for these services. Among children and adults, there is tremendous need for speech-language pathology, audiology, occupational therapy and physical therapy services.

For many children and adults these are rehabilitation services; but for many children, these may be habilitation services because their health care needs result from congenital and developmental disability.

When a child or an adult has adequate access to rehabilitation services, they make important gains in their independence, as well as in their health, developmental, educational, social and economic well-being. It's frightening and sad to think of the disordered level of functioning at which individuals with disabilities are allowed to exist without access to rehabilitation and habilitation services.

End of Noma B. Anderson, Ph.D., Dean

's Comment

State of Tennessee

Department of Commerce and Insurance

Pat Williams,

Company/Organization Not Supplied

We DRASTICALLY need better coverage for mental health everywhere!!! We are supposed to have parity with other health coverage, but I don't see it happening. A mental illness is a brain disorder, a disease of a MAJOR organ of the body. The brain should definitely be covered just like any other organ!!!

End of Pat Williams's Comment

State of Tennessee

Department of Commerce and Insurance

Name Not Supplied,

Company/Organization Not Supplied

In the last several years, it has become public knowledge that Tennesseans receive a much higher rate of prescription medications compared to citizens of almost all other states. I doubt that this is a reflection of poorer health but suspect it is a reflection of poor medical practice and poor coordination of care, in part due to the current incentives for care. In addition, some medical practitioners seem to have a difficult time saying "no" to patient requests for medication, including, and perhaps especially, psychotropic medication.

However, a high use of "off-label" medications, which are especially used in psychiatric treatment and other "soft" symptoms (such as for MS) may in part be at fault.

In my opinion, psychotropic medications are overused. At any rate: 1) They are frequently used for individuals who are actively abusing substances, which render the medications worse than useless and likely harmful, and 2) they are frequently used when the patient is experiencing acute conditions, which do not actually call for medication, but which is requested by the patient to ease an acute negative emotion. In my opinion, this use of psychotropics is potentially harmful for the long-term functioning of the patient. (It should be remembered that anti-depressants especially have a high placebo effect).

As you are no doubt aware, several patients receive multiple psychotropic medications, sometimes more than 3. The practice of so-called polypharmacy is generally questionable regarding the well-being of the psychiatric patient. In addition, psychotropics are often prescribed when the symptoms being treated are side-effects of a physiological condition or side-effects of other medication.

Further, in my opinion, the use of "dual diagnosis," referring to both substance abuse and psychiatric diagnosis and justifying the prescription of psychotropics, is over-used. Regular or heavy substance use, including alcohol, even in those individuals who have had a year's worth of sobriety, can mimic psychiatric diagnoses. Importantly, relapse and long-term recovery from substance abuse does not appear to be aided by psychotropics according to studies of this topic.

The so-called "iatrogenic" impact of psychotropics and withdrawal from psychotropics further complicates the results of unnecessary use of psychotropics. For a layman's summary, please see Robert Whitaker's "The Anatomy of an Epidemic" (2011). This book, which is written by a journalist, suggests that the several years' trend in exponential growth in mental health disability is associated with over-prescription of psychotropics. Of course the increasing rate of disability for mental health is costly to both society and the individual.

The ACA calls for effectiveness studies, and I hope that this approach will be helpful.

However, off-label use of psychotropics and neuroleptics can possibly be brought partially under control. Two of the ten benchmark plans call for off-label medication approval only where peer-reviewed studies support such use. This would be a step towards more healthful use of medication, although the pharmaceutical companies and certain physicians may strongly object. (However, some physicians may welcome these limitations as an easier way of saying "no" to patients.) In addition, there would possibly/likely be monetary savings.

Thank you for your time and attention to this matter.

End of Name Not Supplied's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Ken Lass, PhD,

Family and Children's Services at Centerstone, Inc.

I am writing in re to the state's decisions in choosing which health care concerns should be included in our joining the ACA legislation. I am the Psychologist for Family and Children's Services at Centerstone, Inc., the largest behavioral health provider in the U.S., as well as working in independent practice in Nashville.

Given the prevalence of depression and other mental health disorders in our state, I hope your department gives serious consideration to including mental health as an essential area deserving of funding through the ACA.

I recognize that there are a host of worthy populations in need of care, whether it be cancer patients, heart patients, etc.; but mental health issues, while less conspicuous than other disabilities, nonetheless have ramifications for the patients, their families, and citizens at large. Thank you for your consideration.

End of Ken Lass, PhD's Comment

State of Tennessee

Department of Commerce and Insurance

[Name redacted because of personal health information included.],

Company/Organization Not Supplied

Dear State of Tennessee:

I think the coverage should be similar to the health benefits that the State of Tennessee gives its employees.

I think that for the impoverished, we should include dental care free People who have bad teeth find it harder to be acceptable to people who don't know them They develop diseases, and find it hard to eat.

There could be a high copay means-tested if you want to cover everyone.

That said, I think that plastic surgery for vanity purposes should be eliminated This would apply for facelifts and breast augmentation We can't afford to pay for things that are not deforming If someone is disfigured by an accident, cancer, or other decimating illness, of course you need to help them. Also, sometimes physicians want to remove 2 breasts because of risks after breast cancer If the doctor recommends it, especially if there is a bad DNA and the patient wants it, I agree with them.

I also believe that people who need wheelchairs and other adaptive devices should get some help. There needs to be a means test on this one because many seniors can afford this.

As a mom whose son developed leukemia 5 years ago, I am grateful to the State of Tennessee for such good leukemia coverage He tried chemo for 2 years; it did not do the job. So, he had a stem-cell transplant at Vanderbilt 2 years go At his June bone marrow exam, he was totally clear. While his back still has problems (some vertebrae destroyed by leukemia), over all he is doing pretty well He works part-time and lives with us at age 24 He does normal activities of daily living I think he could work a 30 hour week easily 40 might be too much, as he still need lots of sleep.

My son will be 26 four and one-half months before ACA covers him We are not sure what to do. Maybe the State of Tennessee could offer a high-deductible COBRA-like program for those who turn 26 before ACA. We will be looking at all options closer to January 1, 2014.

My husband has no major problems, but does need to take some pills and occasionally see the doctor.

I've had more problems I had to have both knees replaced I weigh more than I should, although I did lose some weight (20 lbs.) Still far to go I get migraines, although I am having less as I am getting older I had chronic fatigue syndrome many years ago, finally cleared with long-term antibiotics (mycoplasma pneumoniae can last a long time.) I also spent 3 short term visits at psychiatric facilities. This was when they thought I had unipolar depression Instead I have bipolar disorder, which has been under control for 7 years, as long as I take my meds I am lucky in that I have no depression (even in the midst of leukemia) and no mania I see a psychologist and a psychiatrist I've been told by both that I should not work more than 15 hours a week. Instead, I volunteer.

I've tried to give back - so I volunteer for the Tennessee Health Care Campaign I have worked hard to get pesticides out of Metro Schools and succeeded I figure with the mass of kids, I saved some an asthma attack (It's in the literature.) I work on other projects too.

I have materials that tie environmental pollution to health problems, reputable published sources I have been doing stuff on pesticides for 20 years, and it is amazing to me that no one in the Health Department chooses to work on minimizing exposures to improve health Some of the money TN spends would be unnecessary if we stopped using some products, as there are replacements for lots of horrid products.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

I know I wrote a lot, but know that I love Tennessee and I would love to see us in the best health possible Now, back to my weight loss!

End of [Name redacted because of personal health information included.]’s Comment

State of Tennessee

Department of Commerce and Insurance

Ronda Businda,

Company/Organization Not Supplied

First, thank you for taking the time to consider my thoughts and input.

When we brought our daughter home from China in 2008, (she was 28months old) we were NOT informed of her hearing impairment! Thankfully, we had already set up an immediate appointment with her PCP within the first week we were home and it was on that appointment that she failed her hearing screening. Looking back - we knew something was amiss in China as her peers were speaking Chinese, but she did NOT.

If it were not for the mandate regarding coverage of hearing aids and cochlear implants, my daughter would be still, SIGNIFICANTLY behind in both her receptive and expressive language, her articulation - and her literacy!!!

Already behind due to not being informed (we learned later through a translation from her 'memory book' by the orphanage that not only did her caregivers KNOW she was hearing impaired, but there was NO method or module of communication while she lived in China!!!) she has made REMARKABLE progress with first - receiving bilateral hearing aids (3 years old) and then - receiving a cochlear implant on her left ear (4 years old - that is considered LATE to be implanted). Again - would never be able to provide her the GIFT of HEARING without the mandate already in place!!!

Are you ready for this??? :D

Because our state mandate (at the time) was able to assist our insurance company - with intensive speech therapy, deaf education and relentless work on OUR parts as parents, my daughter was able to graduate kindergarten (within her age group/peers) this past May, was the 1st female in her class to reach "big girl reading," and is MAINSTREAMING with her peers to first grade!

Did I mention that she hears music and DANCES???? She is enrolled to be classically trained in ballet this fall.

While I have not updated our blogspot in over a year, please feel free to read her story and her progress at www.miracleofmary.blogspot.com

We are proud of her. We are and have been proud to be living in a state that provided our daughter the ESSENTIAL gift of hearing - AND - READING because of the current mandate.

As fundamental as reading is (ESPECIALLY regarding those that are deaf &/or hearing impaired) and where Tennessee ranks in literacy, it is imperative, essential and with such great urgency to keep the mandate of hearing/deaf services, hearing assist devices/equipment and therapy available to ALL of Tennessee's hearing impaired infants, children and adults!

Those in positions of power regarding this mandate have the great opportunity to continue this gift. On behalf of all who are hearing impaired in the state of Tennessee, THANK YOU in advance for continuing such a crucial and fundamental source of assistance so that these individuals will continue to prosper, thrive and be a most productive member of society!

Sincerely,

Ronda Businda

P.S. (My dear daughter Mary, as I continue to work and advocate for your rights, my hope and dream is that YOU continue to grow strong and confident; that within YOUR continued abilities and attempts to articulate, express yourself and SPEAK - that you realize and value this present freedom of speech so that one day, YOU will advocate for yourself and

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

*other deaf/hearing impaired individuals, so that more lives continue to improve! Keep rockin', my sweet, strong girl!!!
XOXO!)*

End of Ronda Businda's Comment

State of Tennessee

Department of Commerce and Insurance

Tom Presgrove,

Company/Organization Not Supplied

I want to make some comments/suggestions regarding Essential Health Benefits (EHB).

1. How will the exchange handle Employee Retirement Income Security Act (ERISA) preemption of any/all state laws regarding employee benefit plans? ERISA is a major obstacle to most all insurance products.

2. Any Benefits proposal or insurance policies should not contain "Discretionary Authority" language. In 2004 the National Association of Insurance Commissioners (NAIC) proposed the Prohibition of "Discretionary Authority" contained in Health, Life, casualty and Disability Insurance policies known as Model Act 42-1. This has been pushed by the NAIC with very little success. As of this writing, 19 States have adopted this model. The State of Tennessee has had 8 years to make this adaption. Nothing has happened. I am sure you know how devastating Discretionary Language is to policy holders and Claimants. Language in your EHB should disavow Discretionary Language and also add that it survives ERISA preemption.

3. Insurance Companies spend millions of dollars courting, entertaining and lobbying State Insurance Commissioners, aids and politicians in an effort to have favorable legislation and issues passed in their favor. This needs to be changed.

End of Tom Presgrove's Comment

State of Tennessee

Department of Commerce and Insurance

Michael L. Leventhal

Executive Director,
Tennessee Men's Health Network

It is our firm belief that a course of treatment be determined by the patient in consultation with his or her health care provider, not by a government or insurance employee.

Among the many things we have learned about widely diverse populations is that the effectiveness of therapies, including drugs, often vary greatly among different ethnicities, and often from individual to individual within the same population. It is in the best interest of the citizens of this state for a wide variety of therapies and drug treatments to be available for each health condition. And that the patient's share of the cost be affordable to the individual.

As to a basic health insurance plan. The citizens of the state, through their elected officials, representatives, senators, Lt. Governor and Governor have chosen to require those providing

insurance in the state to cover a variety of health benefits that may not be listed among the preventive services provided for in the ACA.

It is important that the state choose a basic insurance plan that covers those benefits, also known as "state mandates." If the plan chosen does not cover those "mandates," then the state has to pick up their addition cost.

End of Michael L. Leventhal

Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

Carl R. Moore

Former State Senator,

Company/Organization Not Supplied

Thank you for coming to Kingsport yesterday. I have two issues for you to consider:

(1) In my opinion TN definitely needs to expand our Medicare eligibility.

(2) TN needs to allow TENNCARE to put more emphasis on adult day care facilities.

Thank you.

End of Carl R. Moore

Former State Senator's Comment

State of Tennessee

Department of Commerce and Insurance

Debra Petree,

Health coordinator,

Knoxville-Knox County Head Start/Early Head Start program

My name is Debra Petree, and I am the Health Coordinator for the Knoxville-Knox County Head Start/Early Head Start program.

All of the plans being considered appear fairly similar. Preventive care, screening and immunizations are covered in all plans. There were no specifics as to how often well checks for adults or children are allowed. We would recommend that for children, the EPSDT schedule from the American Academy of Pediatrics be used. (This would include all recommended lab work.) This allows for frequent well checks during the first 2 ½ years. Since children progress in their development so quickly during this time, any problems in speech, hearing, vision, behavior, and/or cognitive development can be identified in a timely manner, and treatment can begin. Thus giving the child a chance for a better outcome. Yearly well checks for adults and children (beginning at age 3) should also be the standard.

The information provided mentions that "HHS is giving consideration to the CHIP or Federal Employees Dental and Vision Insurance Program as a model for the benchmark." Of the plans up for consideration, only the federal employee plans cover dental checkups for children. At the public hearing in Knoxville, it was mentioned that vision and dental services for children were a priority to be included in the coverage. We believe that it is important that children have a dental exam at least yearly starting at age 1. Dental exams should also be considered for adults. The dental problem experienced by most adults is gum disease. With regular exams and cleaning (and the education that occurs during these exams), this can often be reversed or prevented. The high cost of dental care prevents many of those without insurance coverage from receiving regular preventative care.

Only dental checkups are mentioned as being covered for children. There is no indication that dental treatment is covered. Many children who do not receive regular care beginning at age 1 have many cavities when they are finally seen for the first time. In some cases, this first appointment is made because of a problem. If dental treatment is not covered for the children, the problems will not be addressed because of the prohibitive cost. Therefore, dental treatment for children must be included in the coverage.

We also strongly recommend that in addition to vision screening for children, lenses and frames should also be covered. We frequently have children identified as needing glasses and the parents cannot afford them. Without insurance coverage, many children will be identified as having vision problems but the problems will not be corrected. Children cannot be successful in school if they cannot see clearly enough to read and/or see information at the front of the class.

Finally, we feel that vision exams for adults should also be covered. Many eye diseases are identified through an exam by an optometrist. These would then be covered by the medical portion of the insurance. Without the initial exam, in many cases they would not be found until the problems became severe.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Thank you for your willingness to hear from the public about what needs there are in the state that might be addressed as you go forward in this process.

End of Debra Petree,

Health coordinator's Comment

State of Tennessee

Department of Commerce and Insurance

Jim Moore,

CEO,

The Cumberland Heights Foundation

The Cumberland Heights Foundation wishes to thank you for the opportunity to comment on the services that should be covered under the essential health benefit categories of the ACA. For ease in accessing, the source material links have been footnoted and a reference list appears at the end of the comments.

Services Needed to Address the Problem

Cumberland Heights is a nonprofit Alcohol and Drug Treatment Center, founded in 1964, and is licensed by the Tennessee Department of Mental Health and Substance Abuse Services. Today we understand that addiction is not caused by moral weakness or a lack of personal character – it is a medical disease over which the addict has no control. As with other diseases, without help, the outcome is often tragic. It is estimated that, in Tennessee alone, there are over 640,000 people (1 in 10) with the disease of alcoholism and drug addiction (NIH 2007). Recent estimates revealed that federal, state and local governments were spending over \$467 billion on the associated costs of substance abuse

Cumberland Heights Comments on EHB

August 8, 2012

Page 2

and dependence, or nearly 11% of the nation's \$4.4 trillion budget (The National Center on Addiction and Substance Abuse at Columbia University (CASA 2009). Since Cumberland Heights opened its doors 45 years ago, we have touched the lives of more than 200,000 individuals in recovery – and over 10,000 last year alone. With the passage

of The Affordable Care Act, we will be able to treat more patients who, prior to health care reform, were unable to receive the help they needed because they had no insurance. If the proper services are included in the Essential Health Benefits Package for mental health and substance use disorder treatment (Category E), we estimate that 95,000 Tennesseans who need treatment will finally be able to get it. That is why we are advocating for inclusion of the full range of treatment services that covers all levels of care necessary to address the patients' needs.

Just as cancer patients have a variety of treatments available to address the different types and stages of cancer so too should alcoholics and addicts have the following levels of care to address the progressive stages of the disease with which they present:

Screening, and Assessment; The following two categories of individuals should be afforded screening and assessment services:

Individuals thought to have a substance use disorder

Screening: "The systematic approach to screening and assessment of individuals thought to have a substance use disorder, being considered for admission to addiction-related services or presenting in a crisis situation." This includes, but is not limited to, the following:

The gathering of data "from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender;

State of Tennessee

Department of Commerce and Insurance

Screening for “psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide, and co-occurring mental disorders;”

Cumberland Heights Comments on EHB

August 8, 2012

Page 3

Determining “the client’s readiness for treatment and change as well as the needs of others involved in the current situation;” and

Creating “with the client and appropriate others an initial action plan based on client needs, client preferences, and resources available.”

Assessment: “Assessment is an ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress,” including

Selection and implementation of a comprehensive process that is sensitive to age, gender, racial and ethnic culture, and disabilities that includes, but is not limited to, history of alcohol and drug use, physical health, mental health, and addiction treatment histories, family issues, work history and career issues, history of criminality, psychological, emotional, and worldview concerns, current status of physical health, mental health, and substance use, spiritual concerns of the client, education and basic life skills, socioeconomic characteristics, lifestyle, current legal status, use of community resources, treatment readiness, and level of cognitive and behavioral functioning;

Analysis and interpretation of the data to determine treatment recommendations. (SAMSHA 2006)

Individuals with co-occurring mental and substance use disorder

Effectively serving individuals with co-occurring mental and substance use disorders requires integrated screening and assessment processes according to the Substance Abuse and Mental Health Services Administration.

"Integrated screening is screening that occurs for both disorders. It is a brief process that occurs soon after the individual seeks services. It indicates whether the individual is likely to have a substance use disorder and at least one co-occurring mental disorder. Individuals who screen positive for co-occurring disorders should receive an in-depth assessment....

.....In-depth assessments provide information that is used by the practitioner and the individual to create a treatment plan. It is also useful to establish a baseline of signs, symptoms, and behaviors that can be used to monitor progress over time for individuals with co-occurring disorders.

Cumberland Heights Comments on EHB

August 8, 2012

Page 4

Integrated screening and assessment should occur when an individual enters either service system. It can be conducted by the same practitioner or by different

practitioners. Also, an individual who screens positive for co-occurring disorders may be seen at the same or a different agency for an integrated assessment.

Development of integrated screening and assessment capacities requires:

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Consideration of instruments to be used for each

Development of policies and procedures identifying when screening and assessment will occur, in which agencies and by which staff

Consideration of system level issues such as referrals, information sharing, data collection, staff training and financing. "(SAMSHA 2012)

2. Acute Hospitalization Services; These services are provided in general hospitals, state mental health hospitals, community mental health centers, psychiatric/psychosocial rehabilitation center, and private acute inpatient treatment facilities. (SAMSHA 2011) Treatment in this setting involves

Evaluation—screening and assessment in order to

Detect presence and concentration of substances,

Identify co-occurring medical and psychological conditions,

Determine social situation in order to select appropriate level of treatment after detoxification.

Evaluation serves as the basis for the initial substance abuse treatment plan upon completion of detoxification.

Stabilization—includes assisting the individual through acute intoxication and withdrawal to a medically stable, fully supported drug-free state: Medications may be used. The process introduces individuals to treatment and their role in recovery. Significant others are involved for support as appropriate, maintaining confidentiality.

Cumberland Heights Comments on EHB

August 8, 2012

Page 5

Fostering readiness and entry into treatment—involves preparing the individual for entry into treatment, stressing the importance of follow-through regarding the complete substance abuse treatment continuum of

care. Education about the treatment process and the disease of addiction is critical. (SAMSHA 2008)

4. Non-Hospital Residential Inpatient Treatment; (ASAM 2001) defines these as:

Level III.1 Clinically Managed Low Intensity Residential Services,

Level III.3 Clinically Managed Medium-Intensity Residential Services

Level III.5 Clinically Managed High-Intensity Residential Services

Level III.7: Medically Monitored Intensive Inpatient Treatment.

"The defining characteristic of all Level III programs is that they serve individuals who, because of specific functional deficits, need safe and stable living environments in order to develop their recovery skills." Legal analysis has been performed concluding that these services must be included in the EHB due to the operation of the Mental Health Parity and Addiction Equity Act of 2008 (G. Heller, personal communication, December 20, 2011) . Cumberland Heights has over 40 years of experience in delivering this level of care. Residential Treatment Centers are much more cost effective than hospital stays and are better equipped to address the special needs addiction patients. Our alumni number in the

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

thousands and tell us daily about the effect that residential treatment has had on them and their families. We strongly recommend that the Governor be advised that this level of care is a cost effective and essential service for the treatment of many alcoholics and addicts who present with various stages of the disease.

Cumberland Heights Comments on EHB

August 8, 2012

Page 6

5. Partial Hospitalization: (ASAM 2001) describes these as Level II.5: Partial Hospitalization Programs. They generally feature 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. This level of care has direct access to psychiatric, medical and laboratory services. It is, therefore, able to meet needs which warrant daily monitoring or management, but which can be appropriately addressed in a structured outpatient setting

6. Intensive Outpatient: Intensive outpatient treatment is a planned and organized service in which addiction professionals and clinicians provide several alcohol and other drug treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of nine treatment hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.

7. Outpatient Services: (ASAM 2001) describes these services as Level I: Outpatient Treatment. They encompass organized services that may be delivered in a wide variety of settings. Addiction or mental health treatment personnel provide professionally directed evaluation, treatment and recovery services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols.

8. Ongoing Aftercare and Case Management Services: These services involve client-centered strategies to improve coordination and continuity of care, especially for persons who have multiple needs. Since the 1980s, case management has been adapted to work with persons with substance use disorders, as the disease became increasingly recognized as a multifaceted, chronic, and relapsing disorder that required a comprehensive and continuous approach to treatment. These services can reduce attrition from treatment and improve both psychosocial and drug and alcohol

Cumberland Heights Comments on EHB

August 8, 2012

Page 7

outcomes among persons with substance use disorders, (Vanderplasschen, Rapp, Wolf and Brockaert 2004) as well as maintain the progress gained in higher levels of care. Just as with other chronic diseases such as diabetes and hypertension, the alcoholic/addict needs periodic follow-up with a SUD treatment professional. Without this service, the addicted patient may experience relapse into active addiction. Relapse may require expensive care in a hospital or

multiple readmissions to residential treatment. If healthcare reform's goal of cost-effective and successful outcomes is to be reached, the EHB must include case management services.

Updating the Essential Health Benefit Package

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

In a recent study by the National Institute of Medicine recommendations, were made to The Department of Health and Human Services regarding the process of updating the EHB. The IOM recommended that by January 1, 2013, the Secretary should establish a framework for obtaining and analyzing data necessary for monitoring implementation and updating of the EHB. The framework should account for changes related to health plans such as characteristics of plans (inclusions, exclusions, limitations), ...network configuration, medical management programs (including medical necessity determination processes) ...(IOM 2011).

We urge the Tennessee Department of Commerce and Insurance to provide a mechanism by which providers of mental health and substance use disorder services can report disparate medical management standards without fear of reprisal. This mechanism can be funded by the federal government. Under the new law, states that apply can receive federal grants to help set up or expand independent offices to help

Cumberland Heights Comments on EHB

August 8, 2012

Page 8

consumers navigate the private health insurance system. The programs also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight. Such a mechanism will help inform the DHHS with their task of updating the EHB package annually, beginning in 2016, to promote better health outcomes for both individuals and the broader population. In order to assure the reliability of the information received this mechanism should not compromise the contractual relationship between providers and the various plans or their behavioral health carve outs.

Such a mechanism for reporting disparities would be in line with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). This federal law must be considered in the design and in the annual update of the EHB. The IOM has recommended to DHHS that it establish a National Benefits Advisory Council. This council would be appointed through a nonpartisan process, and be established to offer external advice on updates, data requirements, and the research plan. DHHS will begin developing a plan for identifying data needs and a research agenda that will support the EHB updating process. The ability of the states to provide consistent and usable information reviewed by the National Benefits Advisory Board will be crucial to the updating process.

Cumberland Heights has experienced many instances of disparate treatment of its patients while trying to secure payment for treatment. Consistent with the requirements of MHPAEA, the following concerns should be addressed when creating and updating the EHB:

Disparate reimbursement expenditures between MHSA conditions and medical conditions

In a report by The Rand Corporation, prepared for DHHS, there was found to be a discrepancy between overall reimbursements for mental health/chemical dependency conditions and medical conditions showing that parity compliance is

Cumberland Heights Comments on EHB

August 8, 2012

Page 9

State of Tennessee

Department of Commerce and Insurance

not being met. The department should monitor overall reimbursement

expenditures to ensure parity compliance on a macro scale.

Lack of coverage for the full continuum of care for chemical dependency treatment

Parts of the continuum of care for chemical dependency treatment coverage are

often excluded or severely limited by plan design and treatment limitations. More specifically the importance and effectiveness of the residential level of care is being overlooked. (Reif, Horgan, Quinn, Garnick and Hodgkin 2010) Once

again, we urge the Department to recommend that Tennessee include the full continuum of care for chemical dependency disorders in the EHB.

Conflict of interest related to medical necessity decisions

There is a financial conflict of interest when insurance representatives create their own medical necessity criteria and make medical necessity decisions. This, paired with pre-certification requirements makes it difficult for patients to access proper treatment. We urge the Department to consider close monitoring of the decisions being made by the Insurance Companies. We believe that increased use of Independent Review Organizations (IRO) and the utilization of the Tennessee Health Carrier Grievance & External Review Procedure Act should be encouraged and monitored. Medical necessity determinations should ultimately be made beyond the level of internal appeal for serious conditions that need immediate treatment such as chemical dependency disorders.

Ultimately the need for treatment should be a decision that is made between a patient and their treating physician. Pennsylvania has recognized this principle in the passage of Act 106 of 1989. "Under the Act, the only lawful

Cumberland Heights Comments on EHB

August 8, 2012

Page 10

prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment." In addition such treatment, in the state of Tennessee,

"shall be determined as if necessary care and treatment in an alcohol or other drug

dependency treatment center were care and treatment in a hospital".

Limiting access to treatment using non-quantitative treatment limitations (NQTL)

Under MHPAEA, non-quantitative treatment limitations for substance use disorder services are to be applied by the Insurance Companies in a manner that is no more stringent than the manner that they are applied to medical and surgical conditions. Unfortunately, they are too often being used to improperly limit access to treatment in violation of federal law.. The concurrent review process within the pre-certification requirement makes this problem worse. Again we urge the department to encourage and monitor the use of independent review organizations (IRO) in making medical necessity determinations.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Credentialing and expertise of insurance doctors making medical necessity determinations

Insurance Company physicians often do not have the special expertise and credentials to make medical necessity decisions regarding chemical dependency cases. The stigma associated with chemical dependency exacerbates this problem for doctors with little training or experience with chemical dependency disorders.

Cumberland Heights Comments on EHB

August 8, 2012

Page 11

We urge the department to require proper credentials and expertise for doctors making medical necessity determinations such as certification through ASAM or specialty certification in addiction psychiatry.

Conclusion

In order to comply with the intent of the ACA and MHPAEA it is imperative that the Department recommend to Governor Haslim that all services, included in Category E of Section 1302 (b) (1) of the ACA, be on par with the services for physical health conditions. In other words, those who suffer from the disease of alcoholism and addiction should have the same continuum of care afforded to other people with comparable medical needs resulting from acute and/or chronic disease states. That kind of coverage would be in keeping with the requirements of Health Care Reform.

Sincerely,

James Moore

Chief Executive Officer

The Cumberland Heights Foundation

William W. Leech

Compliance Assistant

The Cumberland Heights Foundation

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Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

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End of Jim Moore,

CEO's Comment

State of Tennessee

Department of Commerce and Insurance

James Arthur, vice chair,
The Knoxville Tea Party

The question of what benefits should be offered by a Tennessee state exchange presupposes that a) any "benefits" are offered at all, and that b) Tennessee will create such an exchange.

To the first point, there are of course no benefits whatever except those which citizens shall be forced to purchase, at greater cost; any new provision is simply a request and a requirement for taxpayers to purchase more expensive policies. These serve as a pretext to subsidize various services, a hidden tax on citizens and employers. Those, in turn, increase the cost of care, and make it less available as a result. The PPACA doesn't give us anything; we pay.

To the 2nd point, The Knoxville Tea Party strongly urges and recommends that Tennessee not create an insurance benefits exchange. Participation is voluntary (as detailed in Sect. 1311 of the PPACA), and not in our interest.

Several states have already indicated they will not participate, including Alaska, Florida, Louisiana, Maine, New Hampshire, South Carolina, and Texas so far.

Among other disadvantages, a state that voluntarily establishes an exchange is liable for the (considerable) cost of running it, and thereby exposes their employers to various penalties, requirements, and punishments under the PPACA.

States that do not create state exchanges will enjoy a competitive advantage and favorable climate with respect to attracting employers and employees from other states. The advantage is not unlike the right-to-work advantage we currently enjoy. This is not something to be tossed aside lightly, nor traded for empty promises of free care that is, in fact, anything but free.

The citizens of the Knoxville Tea Party strongly urge that Tennessee not implement a state exchange. It's not required under the law, and it's not in our interest.

End of James Arthur, vice chair's Comment

State of Tennessee

Department of Commerce and Insurance

Louise McKown,

Company/Organization Not Supplied

These are the thoughts I relayed to you when you were in Knoxville for the public hearing on the Essential Health Care Benefits for insurance plans.

I am on Medicare, so these plans won't affect me much personally. Health care has been a huge issue with me, ever since 1994, when I lost my COBRA two weeks before Medicare kicked in. I was approved for SSDI within six weeks, because I have a rare, progressive, neurological condition that affects my voice, fine motor control, walking and balance. I did not have to hire a lawyer to get on SSDI. I was told this health care system from COBRA to Medicare would be seamless. It was not. I will never forget how disappointed I felt in my country that would let someone with a disability who falls a lot go without insurance. It was then that my eyes were opened to see and meet many people who have had problems with our health care system that are worse off than I am. I am very grateful for the passage of the Patient Protection and Affordable Care Act, for the State of Tennessee now moving forward to develop the exchanges, and for this opportunity to give you my thoughts on the essential health benefits package.

Even though I have multiple disabilities, I have a low paying part time job at an assistive technology nonprofit of which I have 14 coworkers, 7 of whom are part timers, and 6 of the full timers are covered by a plan with a \$4,000 deductible. The one full timer that isn't covered has insurance under his wife's plan at the University of Tennessee, which has a \$500 deductible. Will someone please explain to me how this large discrepancy in these deductibles is fair, just because she works for a large employer? In my office, more and more of the burden of paying for their coverage has been put on them over the past four years. It is such, whatever raises they do get is often wiped out by insurance costs. Additionally, as we dream about what services we could provide that we don't and can't get grants to cover these ideas, is something that I get to see not happen as we pay more and more for insurance. In a country where politicians are always looking out for small businesses to survive and grow, we also need to realize that employees of these companies need health insurance. But because of the cost, these employees often feel like second class citizens. My comments are made off the clock and in no way reflect the opinion of my employer and coworkers.

I do not believe that the exchanges should be considered inferior products, thus forcing employers who also want quality for their employees to have to pay more for existing small group plans that they struggle to pay for now, much less in the future. That is not the essence of what the PPACA was meant to be, and I resent any attempt being made to compromise this effort just to appease insurance companies and their high paid CEOs.

My office works with people with disabilities....all ages, all disabilities, except for behavioral health. I am their public awareness coordinator and systems change advocate. As such, I get the calls about devices – usually high ticket devices that depending on the policy, insurance will not cover. It is time to stop receiving those calls. As I read information as to what all might be covered in the plans, and looked at the survey the Tennessee Department of Commerce and Insurance provided, I scratched my head as to what devices that you are considering as durable medical equipment that will be provided in the essential benefits package. So here is my list of questions.

Will these plans cover?:

- *Wheelchairs and custom built power chairs that often exceed \$2500, which if you look at United Health Car's limit would strap most families in the exchanges to come up with the rest that is needed to purchase this type of chair. Yes, I have seen the teenager sprawled out over his manual chair because insurance would not pay for a power chair he needed. He was totally uncomfortable. So will copays and deductibles be reasonable?*
- *scooters,*

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

- *walkers and rollators. Will you allow people to use the cost of a walker towards the purchase of a rollator like Medicare does, if you aren't going to cover rollators?*
- *Hoyer Lifts, and ceiling mounted track lifts which are very useful for families when dealing with people with spastic cerebral palsy*
- *Hospital beds,*
- *Lift chairs, at least the motor part*
- *Hearing aids for children as was decided in 2011 this state's private insurance plans would cover up to \$1,000. Will you cover these in the exchanges? I hope so, and put a minimum limit of \$999 on the policy. As you recall at the public hearing in Knoxville, we learned from a UT audiologist, that insurance companies are finding a loop hole in this mandate asking what the minimum is they can pay – so no child has yet to get a hearing aid paid for. We will pay more for these kids in special education costs than if we provide them with the hearing aid now so they can be successful in school. What the insurance companies are doing is penny wise for them, but pound foolish for the child and for Tennessee. That practice needs to stop.*
- *Augmentative and Alternative Communication devices for which some companies pay, and some do not. When we tell parents to ask if the company pays for prosthetics and tell them that AAC is a prosthetic for the voice, and was proven in court that it is, still insurance companies say, they don't pay for AAC. So what are families to do? Sue the company? You and I both know that is highly unlikely and so people will go without a way to express themselves. Think about what it would be like for you and your life if you could not talk. Once again when AAC is covered, what will the copay be?*
- *Also, will they cover prosthetics? And how often? Once in a life time, like some plans offer, or every three to five years when they need to be replaced costing at least \$10,000? And how much will the copay be? 80% or 20%? United Healthcare's \$2500 per year for expensive devices is a slap in the face, and means many people go without. Do people who didn't serve in the military to get their replacement prosthesis through the VA, have to go without and be on crutches or use a wheelchair? What about if this could cost them their job to not be able to stand? The Amputee Coalition of America did an analysis that said if every insurance policy covered prosthetics, it would only raise premiums one dime a month. Even if it was \$1 or \$10, to me that is affordable. We can and should do this.*

Big ticket items like prosthetics, communication devices, ceiling track lift systems, hearing aids and power wheelchairs aren't what is driving our medical costs through the roof. For the most part, it is our unhealthy living style. Denying access to these devices further perpetuates the frustration of people with disabilities to be less productive and access to opportunities that the rest of Americans enjoy and take for granted. With disability striking one in five Americans, and one in ten having a significant disability, it is a rare family that doesn't have anyone with a disability. It is time we accept this fact and make accommodations that can allow them to live a full life.

As for wellness plans, I want to relay the story of two women I know who are single, over 50 and have some pre-existing conditions, though not major ones that make it impossible for them to work full time jobs. Neither of them is overweight nor have diabetes, but still they have had their share of health conditions that make them uninsurable in today's market. They can't be at the public hearing to tell their stories and asked me to do so.

One had her own business tutoring students with intellectual and learning disabilities, ADHD, and autism. She had no employees. Her insurance costs were \$436 a month with a \$5000 deductible, before at age 66 she got on Medicare. With that high of payments and deductibles, she rarely went to the doctor for screenings. Once she got on Medicare, she

State of Tennessee

Department of Commerce and Insurance

became anemic and the doctor eventually ordered a colonoscopy. She now has colon cancer that they thought was easy to fight, until the operation proved that it has spread to her liver.

Her very best friend is the executive director of a small, struggling non-profit that many churches in the area support financially because of the work its volunteers do answering calls from people who are depressed, sick, or suicidal; and they make checkup calls for seniors twice a day to see if they are ok and to remind them to take their medications. To get health insurance, she is also in the individual market, because her nonprofit can't afford to over her. She pays \$360 a month with a \$3,500 deductible. She also rarely goes to the doctor for routine tests that someone her age should have. Because of her income and high deductible, she can't afford to go. Because of her friend now having colon cancer, she wants to get a standard, over-the-age-of-50 colonoscopy that everyone is supposed to get. Her insurance says, "Fine, but pay upfront the \$3,500 deductible." She doesn't have it. Colonoscopies can save people's lives. It needs to be standard coverage in the country and this state for everyone over the age of 50.

What upsets both these women is another friend they have works for AT&T and pays \$125 a month per person. Why is it fair for people employed in large corporations to get great rates, and people in small companies get double or triple the rates they have to pay? I will never understand this inequity. Small companies are supposedly the backbone of America, but you are breaking their backs if you continue to allow this practice.

People I love are not expandable. And everyone has people they love. All of us need to have health insurance that is both affordable and of high quality. Going bankrupt because of high health care costs, should no longer be acceptable in this state. Getting the equipment one needs to live a full and happy life is a necessity. Dying should no longer be acceptable because someone can't afford to get routine tests to stop disease in its tracks before it gets out of control. Please build these exchanges to meet the high standards that the Patient Protection and Affordable Care Act promised Americans.

Thank you for your time to do public hearings and reading my comments now.

End of Louise McKown's Comment

State of Tennessee

Department of Commerce and Insurance

Helen Scott RN,IBCLC,RLC,

International Lactation Consultant Association

The International Board Certified Lactation Consultant (IBCLC) is THE lactation professional that should provide Lactation services for our state and IBCLCs should be reimbursed for outpatient services.

The long-term benefits provided by supporting breastfeeding will lead to lifelong health benefits and change the present public health issues that we are dealing with.

See the link below for more details.

<http://www.ilca.org/i4a/pages/index.cfm?pageid=3832>

Thank you for addressing this important issue in our state.

End of Helen Scott RN,IBCLC,RLC's Comment

State of Tennessee

Department of Commerce and Insurance

Stephany Slay-Butler,

Company/Organization Not Supplied

I also would like you to adopt this doctor's recommendation: Dr. B.W. Ruffner, an oncologist and former president of the Tennessee Medical Association was there to urge McPeak to develop a broad plan. He recommended adequate coverage of prescription drugs and behavioral health care, along with preventive and normal care standards. Expectations for the latter include maternity, ambulatory and emergency care, a broad range of preventive and wellness care and rehabilitation. [Article text at <http://bit.ly/MUg0M6>]

Thank you for making sure that Tennesseans get at least the minimal quality standards of health care coverage that we are paying taxes for.

End of Stephany Slay-Butler's Comment

State of Tennessee

Department of Commerce and Insurance

Gene Lawrence, CEO,

Southeast Mental Health Center, Inc.

Comments on Behavioral Health Services:

(1) Any Plan must conform to or abide by the Congressional Behavioral Health Parity Act of 2008, and

(2) should include all Behavioral Health Services as presently approved by the Bureau of TennCare.

End of Gene Lawrence, CEO's Comment

State of Tennessee

Department of Commerce and Insurance

Joel G. Tinnon,

Company/Organization Not Supplied

On behalf of more than 19,000 Tennesseans who are living with HIV and AIDS and countless others that are affected, I urge you to ensure that the Essential Health Benefits (EHB) benchmark for the health insurance exchange established under the Patient Protection and Affordable Care Act guarantees adequate coverage for people living with HIV and AIDS and other vulnerable populations.

This should include the following services:

- A prescription drug formulary that supports the current standard of care for people living with HIV is critical. This standard prescribes a minimum of three antiretroviral drugs to effectively suppress the virus. Thus, plans that cover only one or even a few drugs in each category or class covered by the benchmark would not support the current standard of HIV care. Explicit provisions, such as those provided by for the six “protected” classes on the Medicare Part D drug program, are necessary. The formulary should also include medications to treat side effects and other co-occurring conditions like viral hepatitis.*
- Access to HIV experts, including those trained in infectious diseases, without excessive restrictions, for instance through repeated preauthorization or high co-payments for specialty care.*
- Access to the range of services effective for treating mental illness and substance abuse disorders to prevent inpatient hospitalizations and to support people living with HIV and AIDS in adhering successfully to prescribed care and treatment.*
- Coverage of laboratory tests every three to six months to assess an individual’s response to HIV therapies as well as the development of co-occurring conditions as a result of treatment or disease progression.*
- Case management, which helps those living with HIV and AIDS access services to stay healthy and reduce the use of more intensive and more costly health care services, should be included and defined to include care and services system coordination and navigation, along with HIV/AIDS treatment and care adherence counseling, education and support, both in and outside medical settings.*
- Preventative services, including sexually transmitted infections screening and counseling, FDA-approved contraception and contraceptive counseling, and domestic violence screening and counseling, as well as annual HIV screening and counseling.*

The EHB benchmark should prohibit insurance companies from limiting access to medically necessary health care services through dollar or visit limits on essential services, condition-specific restrictions, excessive cost-sharing, and/or unduly burdensome utilization management and prior authorization requirements.

I sincerely appreciate the opportunity to comment on the Essential Health Benefits Plans under consideration by the department and look forward to working towards a benchmark that meets the needs of people with HIV/AIDS and other vulnerable populations in Tennessee.

End of Joel G. Tinnon’s Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Anthony Fox

Executive Director,

Tennessee Mental Health Consumers Association

On behalf of the Tennessee Mental Health Consumers' Association (TMHCA) I am writing to you to provide comments/input about the health conditions that should be covered under essential health benefit categories.

TMHCA asks that you take the following comments into consideration when recommending an essential health benefits benchmark to Tennessee Governor Bill Haslam.

1. The Patient Protection and Affordable Care Act (ACA) requires mental health treatment within the 10 categories of essential health benefits including behavioral health. Further, Qualified Health Plans in the State Insurance Exchange must comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) for individual and employer sponsored plans regardless of the number of employees. If the State of Tennessee chooses a benchmark plan that does not provide mental health and addiction services at parity, it is required to substitute mental health and substance abuse benefits from another plan that does comply with the parity law. If this becomes necessary, the Tennessee Mental Health Consumers' Association supports substitution of the standard options benefits from a Federal Employee Benefits Plan.

2. Individualized access to medications can be a key to successful mental health treatment and recovery because individual response to particular drugs varies widely between individuals. Under prescription drug benefits, the Tennessee Mental Health Consumers' Association supports following the Medicare Part D model by including all or substantially all anti-psychotic and anti-depressant medications in the Preferred Drug List.

As I'm sure you are aware, TMHCA is the only grassroots peer-to-peer statewide organization staffed entirely by individuals that have and/or currently receive mental health services in Tennessee. In operation since 1988, the association's mission and fundamental purpose is in securing the rights and dignity of our peers (people with mental illness) across our state. People can recover from mental illness; hold jobs, pursue dreams, raise families and live their days in contentment and security. It is entirely possible to make a positive impact in the lives of people with mental illness, but only in a healthcare environment dedicated to and vested in doing so. The ability to purposefully and adequately treat and empower individuals with mental illness rests on sufficient resources.

Thank you for this opportunity to provide comments/input. If you need additional information I can be reached at 615.515.8637.

End of Anthony Fox

Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

G. Bruce Thompson,

Company/Organization Not Supplied

I do not want the change in attachment point to be adopted by the ERISA (B) Working Group or Regulatory Framework (B) Task Force. I strongly oppose the proposed guidelines or amendments that impede rights of employers to self-fund.

End of G. Bruce Thompson's Comment

State of Tennessee

Department of Commerce and Insurance

Name Not Supplied,

Association of Community Cancer Centers

International Myeloma Foundation

National Brain Tumor Society

Susan G. Komen for the Cure Advocacy Alliance

The Leukemia & Lymphoma Society

The Lymphoma Research Foundation

Thank you for the opportunity to submit comments on defining the essential health benefits package for the state of Tennessee. The health care needs of cancer patients are the needs of those both with serious, life-threatening illnesses and chronic health care issues. Treating cancer involves accessing a complex and extensive set of health care services including chemotherapy and prescription drugs, among others. These long-term treatment services can place great financial burden upon patients due to the cost sharing burdens associated with care, even if they are insured.

Both insured and uninsured Tennessee cancer patients and survivors are among those who will benefit greatly from the implementation of an Affordable Health Benefit Health Exchange, as part of implementation of the federal Affordable Care Act (ACA). After much anticipation, the U.S. Department of Health and Human Services (HHS) released a bulletin, on December 16, 2011, to provide guidance to states when determining the essential health benefits (EHB) for state health exchanges, the individual and small group market inside and outside the exchange, and benchmarks for Medicaid and Basic Health Programs. HHS will soon also release federal rules regarding establishment of state EHBs, but they are not expected to be overly prescriptive, leaving most of the details in the hands of state decision makers.

Unless policymakers in Tennessee provide affordable access to comprehensive care, the promise of the ACA will not become reality for cancer patients or survivors. If the state's essential health benefit (EHB) package leans too heavily toward maximizing flexibility at the expense of ensuring access to comprehensive and quality cancer care, cancer patients may find themselves having insurance that is inadequate to meet their health care needs, while being saddled with crippling financial responsibility for their care.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

The State Patients Equal Access Coalition (SPEAC) is a patient-focused coalition of organizations representing patients, health care professionals, and cancer care centers, working collaboratively to ensure that cancer patients have appropriate access to a broad range of approved and medically-accepted anticancer regimens including, but not limited to oral and intravenous drugs, injections, surgery, radiation, transfusions, transplantation, and palliative care. SPEAC believes that every cancer patient should have access to the anticancer regimens recommended by their physician and should not suffer from cost discrimination based on the type of therapy provided or the mechanism of delivery.

We, the undersigned, offer the following road map to policymakers when setting the standards for the state's Health Exchange and EHB package. If you have any questions, please contact Meghan Buzby, International Myeloma Foundation, at 410-252-3457 or mbuzby@myeloma.org.

End of Name Not Supplied's Comment

State of Tennessee

Department of Commerce and Insurance

Jim York,

Company/Organization Not Supplied

The following areas of the ACC should be implemented immediately in the State of Tennessee:

Individual Mandate

Employer Requirements

Expansion of Public Programs

Premium & Cost sharing subsidies to Individuals

Premium Subsidies to Employers

Tax Changes related to health or financing Health reform

Health Exchanges

Changes to private Insurance

State role

Cost Containment

Improving Quality/Health system Performance

Prevention/Wellness

Long Term Care

Medicare Investments

Workforce Training and development

Community based and school based health centers

Public health and disaster preparedness

Requirements for Non-profit hospitals

American Indian Act-reauthorize

Follow coverage and financing guidelines

This new Law is so vital to so many of sick Tennesseans....The complete plans needs to be implemented.

I am a Commissioner on Aging and there is an urgent need to implement this plan for Seniors!!!!!!!

Thank You for allowing input!!!!

End of Jim York's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Stacey Mulder

Chapter President,

National MS Society, Mid South Chapter

Over the last three weeks, the National MS Society, Mid South Chapter has appreciated the many opportunities you and the Department have made available for the public to comment on Tennessee's 2014 Essential Health Benefits. As you heard in Nashville and Knoxville, multiple sclerosis (MS) is unique to each individual living with the disease, but health insurance allows the individual to receive care from a MS specialist and attain treatment to slow the progression of the disease and manage symptoms.

The Mid South Chapter serves more than 9,000 individuals living with MS in Tennessee. The Society estimates that 5-10 percent of people living with MS are uninsured and will be purchasing health insurance on the individual market in 2014. Quality, affordable health insurance available on the Exchange will allow many individuals living with MS to return to the workforce or manage health costs until they qualify for Medicare.

After reviewing the Tennessee Essential Health Benefits Comparison, the Society recommends the State Employee PPO be used as a benchmark plan. The Home Health Care Services, Skilled Nursing Facility, Rehabilitation Facility; Prescription Drug Coverage, Outpatient Rehabilitation

The National Multiple Sclerosis Society...Join the Movement Please remember the National MS Society in your will.

Nashville Office Memphis Regional Office www.msmidsouth.org

214 Overlook Circle, Suite 153 5341 Estate Office Park Drive, Ste 2 www.nationalmssociety.org

Brentwood, TN 37027 Memphis, TN 38119

615/269-9055 901/755-0994

Services, Habilitation Services, Durable Medical Equipment and Clinical Trial Coverage are the benefits that helped us differentiate the plans that would be best for individuals living with MS.

"There is a wide range to this disease," says Judy Brooks. "MS may cause an acute relapse, remitting episodes or can progress with the aging process." Judy Brooks, a long-time volunteer with the Society has lived with MS for more than 35 years. For many years Judy has maintained her health as a beneficiary of the state health plan and like the Chapter believes individuals purchasing health insurance in 2014 should have access to a health plan with similar benefits.

Again, thank you for taking the National MS Society, Mid South Chapter and our MS Activists comments into consideration as you make your recommendation.

End of Stacey Mulder

Chapter President's Comment

State of Tennessee

Department of Commerce and Insurance

Michelle Rice Mary Hord

Director of Public Policy

National Hemophilia Foundation

Mary Hord

Executive Director

Tennessee Hemophilia and Bleeding Disorders Foundation,

National Hemophilia Foundation

Tennessee Hemophilia and Bleeding Disorders Foundation

The National Hemophilia Foundation (NHF) and Tennessee Hemophilia and Bleeding Disorders Foundation (THBDF) appreciate the opportunity to provide comments on Tennessee's essential health benefits (EHB) benchmark plan and benefit options. NHF is the nation's leading advocacy organization working to ensure that individuals affected by hemophilia and related bleeding disorders have timely access to high quality medical care and services, regardless of financial circumstances or place of residence. THBDF advocates on behalf of Tennesseans with bleeding disorders.

Hemophilia and related bleeding disorders are rare, complex genetic conditions for which there are no known cures. Individuals often experience spontaneous and prolonged internal bleeding in the joints and tissues. To effectively manage these disorders, patients often require life-long infusions of clotting factor therapies that replace the missing or deficient blood proteins, thus preventing debilitating and life threatening internal bleeding. While therapies are safer and more effective than ever, they are also more costly than other types of medication. For example, cost of treatment for a person with severe hemophilia can be \$250,000 a year or more. Developing an inhibitor (i.e., an immune response to treatment), complications such as HIV/AIDS, hepatitis and joint diseases, or bleeding as a result of trauma or surgery can increase those costs to over \$1 million.

We are very pleased that the Department of Commerce and Insurance is moving forward and working to determine EHB and a suitable benchmark plan. Given the complex nature of these conditions, it is imperative that whichever plan is chosen as the benchmark (i.e., small group, state, or federal employee), that plan must adequately address the unique healthcare needs of those with bleeding disorders. Specifically, plans to guarantee the following:

1. Access to specialists at federally recognized hemophilia treatment centers (HTCs)

Since 1974, Congress has authorized and funded a national network of HTCs to provide comprehensive, specialized care for individuals with hemophilia and other bleeding disorders. These centers are staffed with healthcare professionals across multiple disciplines including hematologists, physical therapists, nurses, dentists and social

workers that work as a team to provide coordinated care for this complex patient population. In addition to disease and case management, HTCs monitor blood safety and offer many educational programs for individuals and their families.

Numerous U.S. Centers for Disease Control and Prevention (CDC) studies show that individuals receiving comprehensive care at HTCs have a 40 percent reduction in morbidity and mortality, despite the fact that more severe patients are seen at an HTC. Moreover, studies show that patients who use HTCs experience fewer long-term complications and hospitalizations, increasing quality of life and reducing total healthcare care costs over a patient's lifetime.^{1,2}

The ACA specifies that entities covered under section 340B(a)(4) of the Public Health Service Act (which includes federally recognized HTCs) be designated as essential community providers. This designation helps ensure that HTCs are included

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

in qualified health plans and that individuals have access to these specialized healthcare providers (i.e., physical therapist, hematologist). We encourage the State to require plans to permit access to state-based and/or regional HTC.

2. Access to the full range of FDA approved clotting factor products

Clotting factor therapies are biological products (derived from human blood plasma or using recombinant technology). There are no generic equivalents. Moreover, because of the nature of bleeding disorders, an individual's response and tolerability for a specific product is unique. For these reasons, NHF's Medical and Scientific Advisory Council (MASAC) recommends that individuals have access to the full range of FDA approved clotting factor products.³ Limiting access through the use of restrictive drug formularies, such as requiring prior authorization and preferred drug lists, will negatively impact patient care. Therefore, drug benefit designs employing these methods should be avoided and which product an individual uses should be a decision between patient and physician.⁴

3. Access to a range of specialty pharmacy providers

Unlike other types of medication typically bought at a retail pharmacy, clotting factor therapies require special handling, shipping and refrigeration. Additionally, patients often require other products (i.e., syringes, saline), nursing services, and intensive education to manage their complex health condition. These requirements are beyond the ability of a traditional retail pharmacy and are only available through specialty pharmacy providers.

1 Soucie JM et al. Mortality among males with hemophilia: relations with source of medical care. Blood 2000; 96:437-442.

2 Soucie JM et al. Home-based factor infusion therapy and hospitalization for bleeding complications among males with hemophilia. Haemophilia 2001; 7:198-206.

3 MASAC Document #132. (2002). Standards and Criteria for the Care of Persons with Congenital Bleeding Disorders. www.hemophilia.org.

4 MASAC Document #159. (2005). Recommendation Regarding Factor Concentrate Prescriptions and Formulary Development and Restrictions. www.hemophilia.org.

These providers are specially trained to handle the unique needs of the bleeding disorder community and are expected to adhere to the standards outlined by MASAC.⁵ Considering the variability of patient needs and provider services, patients need access to a network of pharmacy providers to properly manage their conditions and live longer, healthier lives. We would also encourage that the agency incorporate provider standards for pharmacies that dispense clotting products.

We thank you for taking the time to review our comments and for giving them your careful consideration. If you have questions, please contact Michelle Rice, Director of Public Policy, at (317) 517-3032 or mrice@hemophilia.org; or Mary Hord, Executive Director, Tennessee Hemophilia and Bleeding Disorders Foundation, at (615) 900-1486 or mary@thbdf.org.

End of Michelle Rice Mary Hord

Director of Public Policy

National Hemophilia Foundation

Mary Hord

Executive Director

Tennessee Hemophilia and Bleeding Disorders Foundation's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

State of Tennessee

Department of Commerce and Insurance

Mary Myers,

Company/Organization Not Supplied

I am writing as the family member of a person with mental illness. Because mental illness is a disease of the mind, it often takes away the ability of the person to think logically. Often the person denies he has an illness and does not seek help. It is difficult at times for a loved one to get the person to seek treatment, and without insurance coverage for psychiatrists, drugs, treatment, and hospitalization if necessary, the task of getting that person to get care becomes almost impossible. The result can be decreased productivity, homelessness, pain for the person and his or her family, or death.

As my family member is an adult, my task of getting help becomes even more difficult. He has had insurance, but the cost with his preexisting condition became prohibitive. Recently my loved one was hospitalized twice at Middle Tennessee Metal Health Institute. The first time he was released to the Mission after 8 days. I was told it was because he was uninsured, it was all about money, and I needed to contact Gov. Haslam. He was recommitted within 2 weeks and kept 3 weeks this time which was long enough to get him on the road to recovery. He should never have been released the first time, and with insurance he might have been held longer that first time instead of wasting time and resources by starting over 11 days later. He fell under safety net which has allowed him to receive services at MTMHI and now at MHC for follow up, These are essential institutions and underfunded. He has no coverage of course for physical health needs should they arise and no preventive care.

Please make sure that coverage for mental health is included at the same level as physical care in our Affordable Care Act. It's the economical thing to do as well as the right thing for this vulnerable segment of our population. It will ultimately save money and lives.

Thank you for your consideration of my input.

End of Mary Myers's Comment

State of Tennessee

Department of Commerce and Insurance

Jaime Ponce, M.D.

President, American Society for Metabolic & Bariatric Surgery

www.asmb.org

Joseph Nadglowski, Jr.

President/CEO, Obesity Action,

Obesity Action Coalition,

The Obesity Society,

American Society of Bariatric Physicians,

American Society for Metabolic and Bariatric Surgery,

and the Academy of Nutrition and Dietetics

In the coming weeks, the State of Tennessee will move forward in selecting a benchmark health plan to define the scope of its essential health benefits package for its health exchange plan. At this critical juncture, the leading organizations of the obesity community implore the state to recognize our country's rising obesity epidemic and the importance of ensuring patient access to the full continuum of medically necessary interventions (behavioral, nutritional, pharmaceutical, psychosocial, medical and surgical) to treat those affected by obesity.

Specifically, we are recommending that the State adopt either of the Tennessee State Employee plans (Partnership PPO or Standard PPO) as the model for the essential benefit program as it covers at least some of the services to treat obesity (healthy diet counseling and bariatric surgery). In addition, we are recommending that the State carefully review services required by the Affordable Care Act (such as intensive, multicomponent behavioral interventions as these services have a B rating from the USPSTF) to make sure they have been added, as required (see addendum regarding ACA mandated preventive services). We see this as an essential step towards the necessary coverage of comprehensive medical treatment. Finally, we recommend that a process for adding "new" essential benefits be developed quickly as safe, effective and evidence based obesity treatments, such as obesity drugs, either are available or will soon be available to citizens of Tennessee.

Obesity's impact on both individual health as well as healthcare costs is well documented. Many large employers, federal programs, such as Medicare, Tricare and the Federal Employees Health Benefits Plan as well as State plans, such as state employee and Medicaid, provide coverage for various obesity treatment services as they recognize both the health improvement as well as cost-savings benefit of such coverage. Unfortunately, this philosophy has not translated down to the small employer and individual markets regarding the fundamental obesity treatment tools – intensive, multicomponent behavioral interventions, pharmacotherapy and bariatric surgery as it appears that private insurers have placed short-term profits and/or concerns about adverse selection above the health of their members as well and their long-term bottom line.

Let's Treat Obesity with the Respect, Urgency, and Action it Deserves!

Too often, for too long, private health plans have excluded coverage for obesity treatment services -- partly due to shortsighted cost savings efforts and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Just like many other serious medical conditions, obesity is a complex, multifactorial chronic disease, which requires a multidisciplinary treatment approach. This approach must encompass the best standards of care, both in terms of the treatments chosen and the clinical environment in which they are delivered. Such treatments should be reimbursed as any other disease therapy would be.

As Tennessee moves forward in choosing an appropriate benchmark plan, the obesity community urges state policymakers to recognize that obesity is a serious chronic disease and deserves to be treated seriously in the same fashion as diabetes, heart disease or cancer. Therefore, when crafting the benefit plan, please afford those affected by obesity with the same medically necessary treatment avenues afforded to all others who suffer from chronic disease.

Addendum

Intensive, Multicomponent Behavioral Interventions

Recently, the United States Preventive Services Task Force (USPSTF) reinforced the medical necessary nature of treating obesity seriously by recommending that clinicians not only screen adults for obesity but offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions for 12-26 sessions in a year.

These updated recommendations are critical given that under the Affordable Care Act (ACA), USPSTF preventive services with an “A” or “B” rating must be covered by all health plans with no patient cost sharing. Unfortunately, we note that all of the 3 small group benchmark plans exclude coverage for “weight loss programs.”

We urge, given the ACA requirements regarding coverage and cost sharing for these preventive services, that the state eliminate any exclusion of evidence-based medical and behavioral management of obesity.

Bariatric Surgery

At the other end of the care continuum, we note that Medicare, Tricare, 47 State Medicaid plans and 44 State employee plans cover bariatric surgery. In addition, Mercer’s 2010 National Survey of Employer-Sponsored Health Plans show that bariatric surgery is covered by 40% of plans with <500 employees AND also that the fastest growth in coverage is in small employers (<500) which is growing at 8% annually.

In evaluating coverage of bariatric surgery, we noticed a trend similar to the one outlined above in the Mercer data. For example, virtually all of the benchmark plans under consideration provide coverage for bariatric surgery with the exception of the three plans that fall within the “largest small group plans” category, which either limit or exclude coverage for surgical intervention.

Prescription Drugs

While coverage for intensive behavioral counseling and bariatric surgery is expanding, the same is not true for obesity drugs. However, the obesity community is extremely hopeful that this will quickly change given the Food & Drug Administration’s (FDA) recent approval of two new obesity drugs (Belviq and Qsymia) – the first new drugs in this class to be approved by the agency in more than 13 years.

While this is a monumental step forward in providing healthcare professionals and their patients new treatment tools, we are concerned that Tennessee is about to move forward on establishing its essential health benefit criteria without

State of Tennessee

Department of Commerce and Insurance

consideration of the potential of these critical new treatment tools. Our review showed, when information was available, that the plans under consideration currently exclude coverage for these treatment tools.

End of

Jaime Ponce, M.D.

President, American Society for Metabolic & Bariatric Surgery

www.asmb.org

Joseph Nadglowski, Jr.

President/CEO, Obesity Action's Comment

State of Tennessee

Department of Commerce and Insurance

Craig A. Becker

President,

Tennessee Hospital Association

The Tennessee Hospital Association (THA), on behalf of its over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and approximately 100,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments on the potential benchmark plan for essential health benefits to be included on Tennessee's insurance exchange. We appreciate the opportunity to provide input as you make recommendations to Governor Bill Haslam.

First, we would like to thank you for your diligent work and willingness to meet with stakeholders on this very important topic. The THA supports the State of Tennessee in operating its own insurance exchange and appreciates our ongoing communication. We believe it is important that Tennessee manage its insurance exchange and look forward to continuing to work with the state to this end.

A foundation of the Affordable Care Act (ACA) is to extend meaningful and affordable health insurance coverage to millions of those who are currently uninsured or underinsured. Defining essential health benefits is critical in determining whether the coverage that will be purchased is actually meaningful. Essential health benefits need to be broad enough to include services that respond to the individual's health care needs, recognizing that the person's age and medical condition will dictate what services are most important; additionally, the diverse needs of the population should be taken into account.

Essential health benefits should be easily understood so that individuals know what their health plan policy does and does not cover. Insurers make coverage and treatment decisions by determining what is "medically necessary," and defining that term is largely left to insurers. No consistent federal or state definitions exist. This lack of a consistent or recognized standard allows insurers to control not only coverage decisions, but also treatment decisions, sometimes overriding clinical standards and the patient's needs. When an insurer uses its definition of medical necessity to exclude costly care, providers should be able to rely on a health plan's prior authorization decision for a procedure or admission; but even under the reforms recently enacted, insurers are allowed to retroactively deny services that they preauthorized. The rules and decision processes that govern essential health benefits, medical necessity, and pre-authorization decisions made by qualified health plans should be transparent so that enrollees understand the limitations of their health coverage. There also should be a means by which a health plan's decisions can be reviewed by an objective third party to ensure that plans properly adhere to appropriate clinical practice guidelines. The essential benefit criteria should also consider the rapid pace of change in medical practice, as clinical, technological and pharmaceutical advances are made.

For reference, the National Association of Insurance Commissioner's (NAIC) definition of Medically Necessary is, "Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine."

Additionally, the THA believes that any limits placed on the services included in the essential health benefits package should be based on clinical best practices and focus on services that are marginally effective and could change with new scientific evidence; such limits may include the number and frequency of diagnostic tests or procedures. Particular types of services should not be eliminated categorically as they may be important to those with certain medical conditions or disabilities.

State of Tennessee

Department of Commerce and Insurance

Reliance on a benchmark plan for defining essential health benefits already incorporates limitations on services and significant deductibles, coinsurance and copayments. We believe that the selection of a benchmark plan should not incorporate all the underlying decisions regarding actuarial value and cost sharing in the state, federal or commercial plan selected as the benchmark. Therefore, the use of the benchmark should be limited to the range of covered services only and not include the actuarial or cost-sharing limits.

If qualified health plans are permitted to modify coverage within a benefit category (as long as the modifications do not reduce the value of coverage), information about any such plan modification should be made publicly available through the state and health insurance exchange information systems.

In addition to the range of needed acute care services, post-acute care is a vital component of comprehensive patient care and includes such services as inpatient rehabilitation, habilitation therapies (e.g. physical, occupational and speech therapies) that enable those born with a disability to attain functional abilities, outpatient rehabilitation therapies (e.g. physical, occupational and speech therapies) that improve, maintain and prevent deterioration of function following illness, injury or disability and home health services. Given not only the best interests of the patient but also the importance of reducing readmissions to hospitals, it is imperative that home health care and other post-acute services are included as essential health benefits. Additionally, the THA believes that restoring or maintaining function should be part of habilitative services and should be offered at parity with rehabilitative services.

The THA also believes that behavioral health treatment coverage for mental health and substance use disorder services should be included at parity with medical benefits.

Thank you for your consideration of our comments. We look forward to working with the State of Tennessee on implementation of the insurance exchange. If you have any questions, please contact me at cbecker@tha.com or 615-256-8240.

End of Craig A. Becker

President's Comment

State of Tennessee

Department of Commerce and Insurance

Jackie Roos MS, RD, CDE, LDN

Dietetic Internship Director/Diabetes Educator,

Memphis VA Medical Center

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

I have lived in Tennessee since 2006 and have also been a registered dietitian for 7 years as well as a certified diabetes educator for the past four years. Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults.[1] According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers.[2] Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." [3] You may not know, but to practice MNT, a Registered Dietitian requires an advanced degree with a dietetic internship. We are well trained to meet the challenges of the nutritional needs of our patients.

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.[4]

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care.[5] Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.[6]

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

Registered dietitians are well grounded in evidence-based practice and are specifically trained in how to reach patients in changing their diets; but the profession has long been without the opportunity to impact significant change because of the lack of reimbursement. Registered dietitian services are cost effective and our team efforts have the potential to help the medical and allied professions address nutrition issues.

Just to bring home the point, can you imagine going into a medical center and being diagnosed with mental disorder? Your physician orders a consult with a psychologist or a psychiatrist who then comes to you in that setting and educates you about your specific mental disorder and sends you on your way without follow-up. In many cases, nutrition services works in this fashion. Registered dietitians do not have the chance to make more of an impact because of the lack of opportunity. What, if on the other hand, you could see that dietitian as an outpatient in an office with an affordable co-pay and those sessions decrease your health risk! What seems very obvious to those of us, who are in the field, would mean a significant cost savings for Tennessee and Tennesseans.

When Governor Haslam ran for Governor, he emphasized the need for all of us to take on personal responsibility. Registered dietitians can help in this area, creating healthier individuals who in turn require less of our healthcare dollars. Please do not hesitate to contact me at 901-523-8990 ext5683 or by email at Jacqueline.roos@va.gov with any questions or requests for additional information. I can make myself available to you as a resource and will do anything I can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens.

End of Jackie Roos MS, RD, CDE, LDN

Dietetic Internship Director/Diabetes Educator's Comment

State of Tennessee

Department of Commerce and Insurance

Dita Rago RD, LDN

Clinical Pediatric Dietitian,

Le Bonheur Children's Hospital

I believe licensed registered dietitians should be included in the Essential Health Benefits law. As you know, obesity is at an all-time high in Tennessee and the US. Obesity leads to hypertension, diabetes, back and knee pain and surgeries, depression, heart disease and a host of other complications. Obesity in TN and the US is costing millions of dollars in health care complications.

Registered dietitians have the expertise to address obesity. They not only have the knowledge of the body and how food is digested and metabolized, but have the knowledge of diets and disease. They are able to assist clients in making gradual change in their eating patterns, while addressing such things as diabetes, so that they can eventually lose weight and be healthier.

Additionally, obesity in children is very high in TN. Overweight children are more likely to become overweight adults and thus face complications. In fact, obese children have been found to have high cholesterol and heart disease. The Dietetic Internships in TN, of which there are 7, are working collaboratively to provide nutrition instruction to children and parents in order to prevent or reverse obesity in childhood. Nutrition instruction at an early age has proved to be beneficial.

As a state, and you as a committee/lawmaker, need to do everything within our power to stop this obesity trend. Registered Dietitians are the experts and are willing to help, so please include us in the Essential Health Benefits.

End of Dita Rago RD, LDN

Clinical Pediatric Dietitian's Comment

State of Tennessee

Department of Commerce and Insurance

Virginia Turner, MS, RD, LDN

Past-President,

Tennessee Academy of Nutrition and Dietetics

The Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association) is committed to improving the health of the citizens of our state. We recognize the important work underway in Tennessee to create the state health insurance exchange and define the benefits and coverage to be afforded to our citizens. As the essential health benefits package is being designed, we believe it should include access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

We believe we have an opportunity to help our state save significant healthcare dollars as Tennessee decision makers make the most cost effective decisions for Tennessee citizens. In fact, we believe that we have an opportunity to be a national leader in these efforts and, again, demonstrate our ability in Tennessee to showcase an innovative way to address a significant national need. It is indeed exciting to know that what registered dietitians have to offer helps your efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

As you well know, the role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults. According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers. Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." In addition, registered dietitians help in access to care in that the counseling we provide can save healthcare resources, leaving nurses and doctors to take care of the other healthcare needs of the patient.

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.

State of Tennessee

Department of Commerce and Insurance

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

Please do not hesitate to contact me at 865.305.9127 or by email at vturner@utmck.edu with any questions or requests for additional information. The Tennessee Academy of Nutrition and Dietetics is available to you as a resource and we will do anything we can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens.

End of Virginia Turner, MS, RD, LDN

Past-President

's Comment

State of Tennessee

Department of Commerce and Insurance

Jane Nuckolls, MA, RD, LDN

System Director

Clinical Nutrition Service,

Methodist Le Bonheur Healthcare

It is with great respect that I am writing to you and requesting inclusion of the Registered Dietitian as a provider in the Essential Health Benefits law.

I am sure you have received many letters written in great detail regarding the benefit our profession can be to Tennesseans. This letter is going to be brief and to the point as to why I believe our services are so important.

For thirty seven years I have practiced medical nutrition therapy in the State of Tennessee. I've worked with children, new mothers; people in the hospital, out patients, community outreach programs, and skilled nursing in every socio economic/culturally group.

Over the past few decades, the link between medical nutrition therapy and reduced mortality/ morbidity in hospitals while demonstrating a positive cost benefit has been well defined. The hospital has been the primary setting for the majority of individuals to receive the benefit of medical nutrition therapy from a registered dietitian.

Today people are sicker in the hospital than they were years ago. In addition, with shorter lengths of stay, the hospital is not the best place to teach people who require medical nutrition therapy how to make permanent lifestyle changes positively impacting their health.

Medical nutrition therapy as an insurance covered benefit has only been in place through Medicare since the year 2000 for people with diabetes and chronic renal insufficiency (CRI) not on dialysis.

Not all insurance plans provide coverage for a registered dietitian for people with diabetes or CRI. In addition, many health plans provide no coverage for a long list of other medical conditions that require medical nutrition therapy interventions such as hyperlipidemias, celiac disease, hypertension, congestive heart failure, cancer, orthopedic problems, behavioral health related issues such as anorexia/bulimia, patients requiring tube feedings as the sole source of nutrition, and even malnutrition.

Let's consider a person with insurance whose plan does not cover medical nutrition therapy, someone for example who has metabolic syndrome. When the Physician refers the person to a registered dietitian and the person learns insurance does not cover the visit with the registered dietitian, they do not show up for the appointment. They may seek and obtain information from sources that are not valid.

Medical nutrition therapy for metabolic syndrome is very similar to treatment for diabetes. Delay in care yields a worsening condition. Failure of the patient to treat the problem nutritionally leads to complications, decline in health, decline in quality of life so that the person stays on a continuum of poor health ultimately requiring hospital stays that are far more expensive than the initial visit with a registered dietitian.

There are people who can and do pay out of pocket for medical nutrition therapy. But lack of access to the registered dietitian produces health disparity pure and simple.

Would not it be better to be proactive and make medical nutrition therapy accessible to all Tennesseans through the Essential Health Benefits law? From my thirty seven years of practice I firmly believe access to medical nutrition therapy

State of Tennessee

Department of Commerce and Insurance

will make a big difference in the lives of Tennesseans as well as reduce the cost of medical care through prevention and achievement of good health!

End of Jane Nuckolls, MA, RD, LDN

System Director

Clinical Nutrition Service

's Comment

State of Tennessee

Department of Commerce and Insurance

Larkin Oates,

Company/Organization Not Supplied

Please opt in to Affordable Health Care. I upgraded my education (two Masters) to have a better job and still cannot afford my preexisting health insurance by Blue Cross Blue Sheild. I have to fight for certain things to be covered. And, my medicationss are too expensive! Some are cheaper in Canada.

Thank you for your consideration.

End of Larkin Oates's Comment

State of Tennessee

Department of Commerce and Insurance

Brian K. Jones MS, RD, LDN, CDM, CFPP

Clinical Nutrition Manager,

Nutrition Services – Sodexo Healthcare

Memorial Health Care System

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

Originally I was going to forward the well crafted e-mail composed by our state dietetic leadership, but then decided that I would just write from my heart. As a clinical nutrition manager of a large hospital my staff and I have the privilege of helping thousands of my fellow Tennesseans with their nutritional issues. While I am proud of our successes, there is only so much we can do in the 2-4 days a patient is in the hospital. For effective management of nutritional issues “out patient” follow up is absolutely vital.

Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist Governor Haslam’s efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

It is time to focus on the nutritional health of Tennesseans. While public health initiatives are vital, providing Medical Nutrition Therapy for those who already have nutrition related conditions will lower healthcare costs and increase quality of life for those afflicted. I have attached some other information from the Tennessee Academy of Nutrition and Dietetics. Please do not hesitate to contact me with questions.

End of

Brian K. Jones MS, RD, LDN, CDM, CFPP

Clinical Nutrition Manager

's Comment

State of Tennessee

Department of Commerce and Insurance

Amanda Carmichael, BS, RD, LDN

Outpatient Dietitian,

Methodist LeBonheur Healthcare - Germantown

I believe licensed registered dietitians should be included in the Essential Health Benefits law.

Registered dietitians are professionally trained to address obesity. They not only have the knowledge of the body and how food is digested and metabolized, but have the knowledge of diets and disease. They are able to assist clients in making gradual change in their eating patterns through behavioral changes. While also addressing such things as diabetes, so that they can eventually lose weight to be healthier and keep the weight off.

As a state, and you as a committee/lawmaker, we need to do everything within our power to stop this obesity trend. Registered Dietitians are the experts and are passionate in helping others make the necessary lifestyle changes, so please include us in the Essential Health Benefits.

End of Amanda Carmichael, BS, RD, LDN

Outpatient Dietitian's Comment

State of Tennessee

Department of Commerce and Insurance

Darla J. Smith, RD, MPH, LDN

Nutritionist,

UT Genetics Center

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

I am a Tennessee native, very proud of my state and its volunteer heritage. I have also been a registered dietitian for thirty-four years and have spent a good part of that career working to help our citizens receive the nutrition services necessary to maintain good health. I have served my profession on the local, state and national level in this regard. Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

In fact, I sincerely believe we have an opportunity to be a national leader in these efforts and, again, demonstrate our ability in Tennessee to showcase an innovative way to address a significant national need. (My mother was a secretary for the Manhattan Project in Oak Ridge, so I know very well the potential Tennesseans have to make a difference not only for Tennesseans, but for our country.)

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults. According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers. Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." You may not know, but to practice MNT, a Registered Dietitian requires an advanced degree with a dietetic internship. We are well trained to meet the challenges of the nutritional needs of our patients.

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT should be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

I tell my undergraduate students that we have to educate our leaders about our potential to help others. With the multitude of scams and quick diet fixes available through the internet, many of our citizens are misinformed about nutrition, especially since nutrition science is ever changing necessitating professionals who can analyze and interpret information appropriately. Registered dietitians are well grounded in evidence-based practice and are specifically trained in how to reach patients in changing their diets; but the profession has long been without the opportunity to impact significant change because of the lack of reimbursement. Registered dietitian services are cost effective and our team efforts have the potential to help the medical and allied professions address nutrition issues.

Just to bring home the point, can you imagine going into a medical center and being diagnosed with mental disorder? Your physician orders a consult with a psychologist or a psychiatrist who then comes to you in that setting and educates you about your specific mental disorder and sends you on your way without follow-up. In many cases, nutrition services works in this fashion. Registered dietitians do not have the chance to make more of an impact because of the lack of opportunity. What, if on the other hand, you could see that dietitian as an outpatient in an office with an affordable co-pay and those sessions decrease your health risk! What seems very obvious to those of us, who are in the field, would mean a significant cost savings for Tennessee and Tennesseans.

When Governor Haslam ran for Governor, he emphasized the need for all of us to take on personal responsibility. Registered dietitians can help in this area, creating healthier individuals who in turn require less of our healthcare dollars. Please do not hesitate to contact me at 865-806-3930, 865-305-8947 or by email at djsmith1006@gmail.com with any questions or requests for additional information. I can make myself available to you as a resource and will do anything I can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens.

End of Darla J. Smith, RD, MPH, LDN

Nutritionist's Comment

State of Tennessee

Department of Commerce and Insurance

Stephen Boyce, M.D.,

New Life Center for Bariatric Surgery

In the coming weeks, the State of Tennessee will move forward in selecting a benchmark health plan to define the scope of its essential health benefits package for its health exchange plan. At this critical juncture, the Tennessee State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), and its many members providing obesity treatment services across the state, implore you to recognize our country's rising obesity epidemic and the importance of ensuring patient access to medically necessary treatment services for the medical and surgical management of obesity.

Specifically, we are recommending that the State adopt either of the Tennessee State Employee plans (Partnership PPO or Standard PPO) as the model for the essential benefit program as it covers at least some of the services to treat obesity (healthy diet counseling and bariatric and metabolic surgery). In addition, we are recommending that the State carefully review services required by the Affordable Care Act (such as intensive obesity counseling as it has a B rating from the USPTF) to make sure they have been added, as required.

Finally, we recommend that a process for adding "new" essential benefits be developed quickly as new, safe and effective obesity treatments, such as obesity drugs, either have been or will be approved and will soon be available to citizens of Tennessee.

Obesity's impact on both individual health as well as healthcare costs is well documented. Many large employers, federal programs, such as Medicare, Tricare and the Federal Employees Health Benefits Plan as well as State plans, such as state employee and TennCare, provide coverage for various obesity treatment services as they recognize both the health improvement as well as cost-savings benefit of such coverage.

Unfortunately, this philosophy has not translated down to the small employer and individual markets regarding the fundamental obesity treatment tools – intensive behavioral counseling, pharmacotherapy and bariatric surgery as it appears that private insurers have placed short-term profits and/or concerns about adverse selection above the health of their members as well and their long-term bottom line.

Bariatric and Metabolic Surgery Coverage

We would like to note that Medicare, Tricare, 47 State Medicaid plans and 44 State employee plans cover bariatric and metabolic surgery. In addition, Mercer's 2010 National Survey of Employer-Sponsored Health Plans show that bariatric surgery is covered by 40% of plans with <500 employees AND also that the fastest growth in coverage is in small employers (<500) which is growing at 8% annually.

In evaluating coverage of bariatric surgery, we noticed a trend similar to the one outlined above in the Mercer data. For example, virtually all of the benchmark plans under consideration provide coverage for bariatric and metabolic surgery with the exception of the three plans that fall within the "largest small group plans" category.

Too often, for too long, private health plans have excluded coverage for obesity treatment services -- partly due to shortsighted cost savings efforts and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

Obesity treatments, like metabolic and bariatric surgery and behavior modification programs, help resolve comorbidities, reduce costs, and transform the lives of patients. In fact, bariatric and metabolic surgery can resolve or improve diabetes (78.1% resolved, 86.6% improved or resolved) and other obesity – related comorbidities after metabolic and bariatric surgery. In addition, bariatric and metabolic surgery is highly cost effective producing longitudinal cost savings and

State of Tennessee

Department of Commerce and Insurance

overall health improvement. The downstream savings associated with metabolic surgery procedures is approximately 2 years, with a range of 16 to 34 months.

Just like many other serious medical conditions, obesity is a complex, multifactorial chronic disease, which requires a multidisciplinary treatment approach. This approach must encompass the best standards of care, both in terms of the treatments chosen and the clinical environment in which they are delivered. Such treatments should be reimbursed as any other disease therapy would be.

As the state moves forward in choosing an appropriate benchmark plan, the Tennessee State Chapter of the ASMBS urges state policymakers to recognize that obesity is a serious chronic disease and deserves to be treated with respect in the same fashion as diabetes, heart disease or cancer. Therefore, when crafting the benefit plan, please afford those affected by obesity with the same medically necessary treatment avenues afforded to all others who suffer from chronic disease.

End of Stephen Boyce, M.D.'s Comment

State of Tennessee

Department of Commerce and Insurance

Jack Geisser

Associate Director, State Policy,

Eisai Inc.

I am writing to you on behalf of Eisai Inc. (Eisai), to formally submit comments regarding the “Tennessee Essential Health Benefits (EHB) Comparison” as delineated by the federal Patient Protection and Affordable Care Act (ACA). Eisai believes it is essential that any benchmark plan that would ultimately be used to establish the EHB ought to ensure access to the most comprehensive pharmaceutical benefit possible while balancing the need for affordable copayment or cost-sharing requirements. Moreover, any chosen plan should have a benefits package and pharmaceutical benefit that incorporates all-encompassing chronic illness prevention, management, and treatment, including that of obesity and management of overweight patients.

As a research-based bio-pharmaceutical company, Eisai is proud of its human health care (hhc) mission to give first thought to patients and their families and to increasing the benefits that healthcare provides. Eisai’s U.S. commercial presence was established in 1997 with the launch of Aricept® for Alzheimer’s disease. Today, Eisai’s U.S. portfolio has grown to include a broad spectrum of treatments for gastrointestinal disorders, epilepsy, and prevention of deep vein thrombosis as well as several oncology and supportive care products. Of these, four medicines carry “orphan drug” status, with patient populations of fewer than 200,000 people. These include three oncology treatments, as well as, BANZEL®, an approved medication for the adjunctive treatment of Lennox-Gastaut Syndrome (LGS) in children 4 years and older, and adults.

Choice in Drug Therapy

While the ACA includes pharmaceutical coverage as part of the EHB package, there is no guarantee that the coverage will be adequate unless the state chooses a benchmark plan with robust pharmaceutical benefits. While current federal guidelines will permit a formulary class to have only one drug in a class, this does not guarantee adequate coverage to patients, particularly those that may require multiple prescription therapies to address their medical needs. While Eisai believes that physicians should always have access to the full portfolio of treatments available to help fight disease in their patients, some conditions are more sensitive than others and should never be restricted in terms of the number of drugs a physician has to choose from. For example, patients with epilepsy frequently need to take several adjunct medicines, in addition to the originally prescribed treatment, just to gain control of breakthrough seizures. Eisai’s prescription drug BANZEL®, is an adjunctive treatment for LGS in children 4 years and older, and adults. LGS is an orphan condition that can be debilitating for those afflicted, sometimes having upward to 100 seizures a day. Having one medication in a drug class such as an anti-seizure medication would not suffice for these patients.

Cancer is another example of a disease that should never be confined to the one drug per therapeutic class standard, as clearly demonstrated by Congress in creating a protective class for cancer drugs under the Medicare Modernization Act (MMA) (P.L. 108-173). Potential limitations on the physician and patient’s choice of cancer medications within a drug class could seriously jeopardize a patient’s survival. Physicians must have access to a thorough portfolio of drugs to treat their patients’ medical conditions.

Treatment and Management of Obesity and Chronic Illness

According to the Centers for Disease Control, the incidence of obesity in the United States has risen to more than 35%. This means more than one-third of all adults are considered obese (defined as a body mass index (BMI) of 30 or above). Subsequently, nearly 31% of Tennessee adults are considered obese. Obesity is linked to a variety of chronic illnesses, including diabetes, heart disease, stroke, sleep apnea and cancer. These ailments not only jeopardize the lives of

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

patients, but destroy their quality of life, as well as drain valuable health care resources from the state and businesses in the overall economy. In particular, the disease of obesity is costing the country billions of dollars per year. In 2008, approximately \$147 billion was spent on obesity and obesity-related care. These estimates are expected to rise along with the growing crisis of obesity.

Per this request for comments, the State of Tennessee is currently considering options for a benchmark plan, which in turn would establish the confines of what the EHB would be until a review can again be conducted in 2016. Because of the approach that the Centers for Medicare and Medicaid Services (CMS) have taken, benchmark plans should encompass existing state mandated benefits without incurring costs to the state. This will ensure patients are protected in a manner consistent with the minimum standards of Tennessee law when the ACA was passed. However, there are other options that are important to consider.

Many plans offer varying degrees of coverage for weight-related management and treatment services. Approaches that do not include all options, including pharmacotherapy, will be less than sufficient in the current and future climate in which approximately 31% of Tennessee residents are considered obese. Unfortunately, the draft comparison provided does not address any factors such as weight and obesity management and treatment. Often plans place limits on nutritional counseling and then make a leap to treat the morbidly obese. Some plans lack coverage for, or place severe restrictions on anti-obesity drugs to assist people in losing weight before they become morbidly obese. Plans then will often cover bariatric surgery as treatment for what is generally considered the “morbidly obese.” “Morbid obesity” would typically be measured as a BMI greater than 40, according to the Agency for Healthcare Quality Research.

With the “obesity” measure thresholds beginning with a BMI of 30 or greater, there are few options until “morbidly obese” patients need care, which would deem them eligible for bariatric surgery. Prior to a patient becoming eligible for bariatric surgery, the only intervention that many plans provide are recommendations in changing diet and exercise (i.e., nutrition counseling), with some providing some additional comprehensive counseling. Another option is for coverage of weight-management programs, which many, but not all plans now cover. Any chronic disease program for overweight or obese patients that includes prevention, management, and treatment should include all elements of treatment, including possible pharmacotherapies.

The ACA requires coverage of preventive, wellness, and chronic disease management as part of the “essential health benefits,” however, the extent of that coverage is uncertain. The inclusion of certain diseases and the term “chronic disease” is not well-defined. Qualified health plans may have a variety of benefits that could fall within their definition of “management and treatment” of chronic disease. These benefits could exclude pharmacotherapy. Therefore, interpretations in what may include treatment for overweight or obese patients as a disease or a medical illness may vary throughout the time a patient may have the disease. Moreover, plans will likely have differing variations of benefits that fall under this sub-heading depending upon considerations of the actuarial value. Overweight and obese patients require treatment through all stages of their illness to formally manage the condition.

While it has been several years since new pharmacotherapies have been introduced into the market for weight loss, there are new medicines recently approved to help bring hope to patients suffering from obesity. Because the benchmark plan, and in turn the EHB will not be revisited until 2016, it is imperative that Tennessee choose a benchmark plan in 2012 that will encompass all innovative treatments or at least allow coverage for future treatments prior to 2016. Obesity is a current and ongoing crisis, with immediate cost implications that should not be ignored for an additional four years.

Thank you for the opportunity to comment on the benchmark plan and essential health benefits. If you or your staff have any questions or would like to discuss Eisai’s comments further please contact me at jack_geisser@eisai.com or at 551-579-2793.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

End of Jack Geisser

Associate Director, State Policy's Comment

State of Tennessee

Department of Commerce and Insurance

Yarnell Beatty

Director, Legal & Government Affairs Division,
Tennessee Medical Association

This correspondence is in response to the July 11, 2012 Media Release by the Department inviting public comment about the health conditions that should be covered under essential health benefit categories under the federal Patient Protection and Affordable Care Act. Please accept these comments on behalf of the nearly 8000 physician and medical student members of the Tennessee Medical Association (TMA) which is the largest physician organization in Tennessee.

First, thank you for keeping our organization informed about the health insurance exchanges and essential health benefits package. The Tennessee Essential Health Benefits grid obviously required a great deal of work to create. It is an invaluable resource for comparing plans, for reflection about services that should be considered, and also identifying State mandates. We have found the documents and slides provided on the exchange website throughout this process to be informative and helpful and staff accessible. Our members appreciate the Department and Bureau's transparency.

Second, we appreciate the opportunity to provide input about the health conditions that should be covered. TMA representatives were able to attend two of the statewide meetings; providing oral testimony at the Cleveland meeting on August 1. As physicians will be the primary deliverers of health care when the exchanges are operational, the essential health benefit package is of the utmost importance to our members and their patients.

Rather than begin by addressing specific issues in the ten (10) categories of essential services we will focus on some general principles after a few thoughts about prescriptions drugs. The Department's benefit comparison chart reveals that for the United HMO and the small group plans prescriptions are covered by riders in each option. The chart also indicates that non-preferred and specialty drugs require precertification in the Federal Plans. This means that access to medicines may not be well defined in these possible benchmarks. Patients' access to appropriate pharmaceuticals is essential for adequate care. At a minimum, the TMA would request that allowed drugs match or exceed those available for TennCare patients: 2 prescription drugs and 3 generics per month and include the long list of additional drugs, mainly for generics, used in combination for chronic diseases that do not count against the benefit limit.

Our other comments are more for general consideration as we, at this time, do not endorse any particular one of the ten potential benchmark plan designs although the state and the federal employee plans seem the most intriguing to us at this time. Because of the federal mandate, many Tennesseans will be entering the insured health care market for the first time or after a long absence. Thus, plans in all tiers should absolutely include a generous physician office visit benefit so these patients' who may have long-untreated conditions and chronic conditions can be adequately treated in order to promote cost savings to the health care system and minimize "downstream" costs in the forms of emergency room visits and in-patient hospital care.

The TMA believes that it will be critical for patients to be able to know that their physicians are participating in the health insurance plan that they are considering. The State will be building an Internet website to help patients make their choices. The website should include up-to-date information about the physicians, surgery centers, and hospitals participating in each plan and whether the participating physicians are accepting new patients. It is equally important to patients and primary care physicians that in-network specialist physicians also be listed online.

As actuaries are struggling with requirements to keep within the 60, 70, 80, and 90% estimated benefits costs for bronze through platinum plans, they may reduce the actuarial value of the less generous plans by limiting services for home health, skilled nursing, medical rehabilitation or behavioral health services. It is the TMA's position that even bronze plan limitations should be no less than those specified in the benchmark plan that the State chooses.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

The TMA is committed to enhancing the health of all Tennesseans. Insurance exchanges, if well designed, well implemented, and well monitored, will enhance the welfare of many citizens by opening new options for insurance for those employees in small businesses and by making available affordable, more comprehensive insurance for individuals. We appreciate the challenge the State has in balancing the costs of those plans with designing metallic tiers that meet the medical needs of Tennesseans but we believe a generous physician office visit benefit offers the best chance to meet this challenge.

Once again, thank you for the opportunity to provide these comments on essential benefit coverage.

End of Yarnell Beatty

Director, Legal & Government Affairs Division's Comment

State of Tennessee

Department of Commerce and Insurance

Nadine King, PhD, R.D., L.D.N.

Nutrition Consultant,

Tennessee Academy of Nutrition and Dietetics

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

I have had a private practice for the past 18 years as well as taught, consulted and completed my PhD.

Tennesseans need professionals to care for them and teach them coping skills for their environment.

If we had more time to document the needs, you would see the overwhelming need for RDs. When you are ready to write the plan...just think, do I want a nurse's aide doing my surgery since she had a course in cleaning the Operating Room or do I want a M.D. with years of schooling and experience?

Thank you for your time and consideration.

End of Nadine King, PhD, R.D., L.D.N.

Nutrition Consultant's Comment

State of Tennessee

Department of Commerce and Insurance

Ellyn Wilbur

Executive Director,

Tennessee Association of Mental Health Organizations

The Tennessee Association of Mental Health Organizations is a trade association that represents community behavioral health providers across the state of Tennessee. Our system provides crucial services to some 90,000 adults and children each month who have severe mental illness, substance abuse disorders, or serious emotional disturbances. These services include a continuum of evidence based options that are provided based on an individual's strengths and needs.

Currently, approximately half of the individuals we see are uninsured. For many of the uninsured we serve throughout our system, there are no resources to pay for services that are truly necessary for them to function at work, home and in their communities. It is for this type of person that the Essential Health Benefits are truly "essential". Over the past 15 years, with increased emphasis on evidence based services and cost containment, the behavioral health system has become proficient in providing services that are effective and efficient and frequently less costly than traditional services that are covered in a standard health insurance plan.

It is with this rich history and experience that we offer the following recommendations for consideration when determining the essential health benefits for Tennessee:

- We are aware that the EHBs must comply with the Mental Health Parity and Addiction Equity Act. We believe that the types of mental health and substance abuse services covered by the Plans must provide positive outcomes and be cost effective. Again, many of these services are not available in a standard employer health plan.*
- We recommend that the behavioral health services in the TennCare benefit package be used as reference and as necessary, the benchmark plans be supplemented with these effective services.*
- Medications are an important component of treatment for mental illness and frequently for substance abuse. We recommend that all psychotropic medications and medications typically used for depression be included in the medication benefit. Our medical providers have advised us that off-label use of certain medications frequently yields positive results. For this reason, we recommend that off-label use of medication be permitted as long as it is prescribed by a licensed medical practitioner.*

We appreciate the opportunity to provide feedback on the selection of Essential Health Benefits for Tennessee and are happy to provide additional information or answer any questions you might have. Thank you for your consideration.

End of Ellyn Wilbur

Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

Amy A. Brewer, MS, RD, LDN

Lead Interventionist Look AHEAD Study,

Div. of Endocrinology

The University of Tennessee Health Science Center

Thank you for taking the time to hear our concerns about health care coverage for the state of TN.

During the forum at UTHSC in Memphis TN on August 3rd, I mentioned how nutrition education from Registered Dietitians can positively impact the health of Tennesseans in a way that can lower overall health care costs.

“Give a man a fish and you feed him for a day, show a man how to fish and you feed him for a lifetime.” Nutrition counseling has the same impact...empowerment for the long term.

Diabetes, Obesity, Heart Disease are major health issues for Tennesseans yet citizens have little to no support for nutrition counseling in most health care plans.

When we empower people to take control of their health behaviors through nutrition counseling we can eliminate or reduce the number of medications needed to manage their diabetes/hypertension/heart disease risk because lifestyle changes impact multiple physiological systems not just one.

The hundreds of study patients I have worked with in the past 24 years tell me repeatedly how important their nutrition counseling has been in helping them manage their diabetes/weight/blood pressure/heart disease. No patient says “I want to be on more medications to control my diabetes/blood pressure/cholesterol, etc...” What they do say is “show me how to manage my diabetes/weight/blood pressure/heart disease so I can get off these medications.”

The American Heart Association, the American Cancer Society and the American Diabetes Association all mention nutrition as first line of approach to managing disease.

Major clinical trials have shown the positive impact nutrition counseling has on health and health risks:

☐ *In the Trials of Hypertension Prevention Phase II, overweight subjects who received lifestyle counseling for weight loss had the greatest reduction in blood pressure and clinically significant reduction in cardiovascular disease risk than the controls. (Ann Intern Med., 2001 Jan 2 and*

☐ *In the Diabetes Prevention Program, subjects at risk for diabetes who received the lifestyle counseling had greater changes in weight and clinically significant reductions in diabetes development health risks over the medication and placebo arms. (Diabetes Care, September 2006) The cumulative incidence of diabetes development remained lowest in the lifestyle group even after 10 years of follow up. (The Lancet, October 2009)*

Also, lifestyle counseling improved the general health, physical function and vitality of subjects and decreased body pain in the lifestyle group of the Diabetes Prevention Program. (J Gen Intern Med., 2012 Jun 13)

☐ *In the Look AHEAD study the year 1 and year 4 results consistently showed that nutrition counseling for weight reduction and improvement in physical activity had a significant impact on blood sugar control, hemoglobin A1C, HDL cholesterol, blood pressure, and level of fitness than the controls in obese adults with Type II diabetes. (Diabetes Care, June 2007 and Arch Intern Med 2010 Sept 27)*

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

📄 *In a recent 2 year study assessing the impact of weight loss counseling in clinical practices, the group receiving the enhanced lifestyle counseling had the greatest loss of weight and this weight loss was sustained longer than the other assignment arms. (N Engl J Med., 2011 Nov 24)*

Registered Dietitians can provide cost effective health care to Tennesseans by giving them the tools to manage their diabetes, obesity, heart disease for a lifetime. Just imagine what impact we could have on the health of Tennesseans if everyone had access to Registered Dietitians!

End of Amy A. Brewer, MS, RD, LDN

Lead Interventionist Look AHEAD Study's Comment

State of Tennessee

Department of Commerce and Insurance

Gloria Brien, MS, RD, LDN, CDE

Registered Dietitian and Certified Diabetes Educator,

Company/Organization Not Supplied

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

I am a Tennessee native, very proud of my state and its volunteer heritage. I have also been a registered dietitian for sixteen years and have spent a good part of that career working to help our citizens receive the nutrition services necessary to maintain good health. I have served my profession on the local and state level in this regard. Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars. In fact, I sincerely believe we have an opportunity to be a national leader in these efforts and, again, demonstrate our ability in Tennessee to showcase an innovative way to address a significant national need.

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults. According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition. Nutrition plays a very important role in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers. As a RD who is also a Certified Diabetes Educator (CDE), I help individuals with diabetes learn to manage their disease and prevent the long-term complications of diabetes.

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

With the multitude of scams and quick diet fixes available through the internet, many of our citizens are misinformed about nutrition, especially since nutrition science is ever changing necessitating professionals who can analyze and interpret information appropriately. Registered dietitians are well grounded in evidence-based practice and are specifically trained in how to reach patients in changing their diets; but the profession has long been without the opportunity to impact significant change because of the lack of reimbursement. Registered dietitian services are cost effective and our team efforts have the potential to help the medical and allied professions address nutrition issues.

Just to bring home the point, can you imagine going into a medical center and being diagnosed with mental disorder? Your physician orders a consult with a psychologist or a psychiatrist who then comes to you in that setting and educates you about your specific mental disorder and sends you on your way without follow-up. In many cases, nutrition services works in this fashion. Registered dietitians do not have the chance to make more of an impact because of the lack of opportunity. What, if on the other hand, you could see that dietitian as an outpatient in an office with an affordable co-pay and those sessions decrease your health risk! What seems very obvious to those of us, who are in the field, would mean a significant cost savings for Tennessee and Tennesseans.

Please do not hesitate to contact me at 731-695-0592 or by email at gloriabrien@gmail.com with any questions or requests for additional information. I can make myself available to you as a resource and will do anything I can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens.

End of Gloria Brien, MS, RD, LDN, CDE

Registered Dietitian and Certified Diabetes Educator's Comment

State of Tennessee

Department of Commerce and Insurance

Marilyn Holmes,

Company/Organization Not Supplied

I am a registered dietitian (RD) and licensed in the State of Tennessee. Additionally I am member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). Our nutrition professions is committed to improving the health of the citizens of our state. We recognize the important work underway in Tennessee to create the state health insurance exchange and define the benefits and coverage to be afforded to our citizens. As the essential health benefits package is being designed, we believe it should include access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

The benefit of nutrition in health promotion, disease prevention and disease management is clearly documented in the literature. RDs are the most cost-effective, qualified healthcare professional to provide medical nutrition therapy (MNT). MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals.

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

Should you have questions do not hesitate to contact me at the e-mail address below or at 615 343 2638 (Work) or 615 790 0656 (Home). Thanks in advance for your consideration of this matter.

End of Marilyn Holmes

's Comment

State of Tennessee

Department of Commerce and Insurance

Kristin Parde

Senior Director

State Advocacy,

PhRMA

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on Tennessee's Essential Health Benefits Comparison. PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

We appreciate the State's effort to engage the public and stakeholders on this important subject. We offer the following comments for consideration in regard to the pharmaceutical benefit in any essential health benefits benchmark plan:

- Comprehensive drug coverage leads to better health outcomes. Countless medical studies have shown the link between patient compliance with prescribed drug regimens and good health outcomes. Barriers to access, including inappropriate coverage restrictions and limits, often decrease patient adherence to needed medical regimens, resulting in poor health outcomes. States should ensure that benchmark policies will not make prescription compliance more difficult for patients. Benchmark policies must cover drugs that physicians decide patients need.*
- Comprehensive drug coverage reduces use of avoidable hospital visits and other costly medical care. Patients that come off their medicines often require increased doctors' office and emergency room visits as their conditions deteriorate. This can lead to costly, last-minute medical interventions to save patients whose conditions could have been managed more effectively by adhering to drug therapy. As a result, patients that adhere to their prescribed medicine regimens often have lower total medical costs than non-adherent patients.*
- Comprehensive drug coverage is particularly important for patients with chronic disease. Medication adherence is particularly important for patients with chronic disease, and it is vital that cost-sharing rules account for their ongoing health care needs. Patients with chronic disease often require prescription drug treatments year after year and would face high out-of-pocket costs if their prescriptions were subject to a deductible. Providing prescription drug coverage that is not subject to a deductible will lessen financial barriers to compliance and is also consistent with the Affordable Care Act, which stated that Essential Health Benefits should be similar to typical employer-sponsored coverage. According to a survey by the Kaiser Family Foundation, prescriptions are not subject to a deductible in most employer plans.*
- To realize the clinical and economic benefits associated with comprehensive drug coverage, the benchmark plan must provide access to needed medicines and a meaningful choice of treatments. The benchmark plan should offer sufficient choice of medicines to provide patients and providers with a range of treatment options consistent with current standards of medical practice, as is customary in the employer market. For example, standards of care established by respected medical professional societies show that the inclusion of only one drug per therapeutic class is insufficient to*

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

ensure patient access to needed care. Different patients often respond to drugs in the same class differently, and many conditions require treatment by a combination of medicines in the same therapeutic class. Therefore the benchmark plan must not impose arbitrary restrictions on access to medication.

- The benchmark plan must not cover prescription drugs in a discriminatory fashion. The Affordable Care Act forbids qualified health plans from discriminating against individuals based on health care needs. It also requires that benefits must not be designed in a discriminatory fashion. The benchmark plan should not include coverage limits and restrictions that would unfairly burden patients with significant health care needs. For example, the benchmark plan should not impose class-based coverage restrictions that would drive up costs—and hurt access—for patients with complex medical conditions in need of combination therapy. Formularies should also not include tiered cost-sharing designed to discourage enrollment among individuals who need specialized medicines, such as those used to treat certain cancers.*
- Tennessee should establish clear and meaningful standards for comparing Qualified Health Plans (QHP) to the benchmark plan. As states evaluate whether a Qualified Health Plan offers coverage on par with the selected benchmark plan, an analysis of actuarial equivalence will not be sufficient. States should develop guidelines for QHPs that reflect multiple aspects of coverage, including the degree of choice available to patients and providers; processes for updating coverage to reflect evolving standards of care; and protections for vulnerable populations. Plans should also have procedures in place to preserve treatment protocols for new beneficiaries and should not be permitted to require patients to repeat step therapy when they change plans. While clear processes to seek exemptions from coverage decisions are necessary to ensure that patients can always receive appropriate treatments, these processes are not a substitute for providing sufficient choice of medicines.*

In conclusion, we appreciate the opportunity to provide comments on essential health benefits and your consideration of our comments. Please feel free to contact me with any questions.

End of Kristin Parde

Senior Director

State Advocacy

's Comment

State of Tennessee

Department of Commerce and Insurance

Maureen O'Connor

Director of Public Policy,

Le Bonheur Children's Hospital

Thank you for the opportunity to comment on the essential health benefits policy that you are developing. It is imperative that you take into consideration the special needs of all children given their continuous stages of development. Children require age appropriate care to ensure that they develop and grow to their full potential. Using a commercial plan as a benchmark may leave gaps in coverage for children. We respectfully ask that the essential benefits be developed by combining benefits from multiple plans, including TennCare, that best serve children and create a lifetime of good health. The following are points that should be given serious consideration:

- Children are in continuous stages of development, so their capabilities, physiology, judgment and responses to interventions constantly change and must be closely monitored. Additionally, a segment of children suffer from chronic conditions that affect their development and that require specific attention in order to generate, maintain and restore age-appropriate functioning. To adequately address these unique needs, the essential health benefits package should provide children with access to all medically necessary services, similar and equal to the standards used in Medicaid's EPSDT benefit.*
- Using an existing commercial plan as a benchmark may leave gaps in coverage for children, particularly those with special health care needs. For example, many commercial plans do not cover specialized services such as ancillary therapies, home health care and durable medical equipment, all of which may be medically necessary in the treatment of children with chronic illness.*
- As the HHS bulletin acknowledged, providing habilitative services to maintain or keep a function is "virtually unknown in commercial insurance". It is critical for children with severe disabilities to have the right habilitative services to ensure that they achieve their highest level of productivity and prevent any regression of function.*
- Any benchmark plan selected by the state must include the full scope of maternity care (preconception, prenatal, labor and delivery, and postpartum), as recommended by the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. These services reflect the latest clinical evidence available regarding effective, appropriate care to ensure the best health outcomes for women and their newborn children.*
- We support many of the statements made at the town hall meeting on Friday. It is important that children have coverage for services that are essential to their growth and development including cochlear implants, catheters and obesity counseling.*

Thank you for the opportunity to comment. Please let me know if you have any questions.

End of Maureen O'Connor

Director of Public Policy's Comment

State of Tennessee

Department of Commerce and Insurance

John J. Dreyzehner, MD, MPH, FACOEM

Commissioner,

Tennessee Department of Health

- 1. We recommend an emphasis on primary care in outpatient setting with care coordination/education and specialist access*
 - a. Disease prevention and wellness office visits, sick visits, lab work, X-rays, prescriptions, and specialty care referrals where medically indicated to improve diagnostic accuracy and disease management.*
 - b. For adults, utilize standard history, with behavioral screening, immunization review, and patient education. Much of this could be accomplished with an annual Health Questionnaire*
 - c. Case management service for vulnerable populations such as teen parents, medically fragile / high utilization children, and chronically ill children and adults.*
 - d. Patient navigation services for expensive multi-provider care (e.g., cancer treatments, neonatal intensive care).*
 - e. Immunizations as recommended by the Advisory Committee on Immunization Practices, including and immigrant/international travel vaccines*
 - f. Patient education: Individual or group education and nutrition therapy for prevention of behavior-related chronic diseases, including tobacco dependence, obesity, diabetes, STDs, hypertension, and other preventable diseases.*
- 2. We recommend an emphasis on beginning prenatally and including oral health for children's services*
 - a. Prenatal care: Pre-conception counseling, pregnancy testing, obstetrics management*
 - b. Breastfeeding education and support*
 - c. Immunizations: All vaccines recommended by CDC and ACIP including back to school*
 - d. Annual health screenings modeled upon the Medicaid EPSDT Program (Early, Periodic, Screening, Diagnosis and Treatment), including vision and hearing screening and treatment.*
 - e. Oral health screenings and prophylaxis, including examination, sealants, prophylaxis (including cleanings), at age 12 months or first tooth eruption, whichever is sooner.*
 - f. Nutrition counseling: focused on obesity, diabetes, and other known diet-related diseases.*
- 3. We recommend mental health evaluation and treatment services availability*
 - a. Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify persons at-risk and for whom substance use disorders services is needed is a key primary care intervention.*
 - b. Available behavioral health services should include: behavioral health counseling, outpatient treatment with laboratory services, emergency care with crisis intervention, care for addictions, and inpatient care.*
 - c. Access should assured to emergency mental health care 24/7 and initial non-emergent appointments within 3 weeks. A 24 hour crisis line should be available.*

State of Tennessee

Department of Commerce and Insurance

d. Care coordination should be available for suspected or substantiated child physical, emotional, or sexual abuse and/or neglect in both inpatient and outpatient settings.

4. Outpatient based communicable disease prevention services including preventive counseling and treatment for Sexually Transmitted Infections (STIs), hepatitis, TB and other communicable diseases are recommended.

5. Family planning services and supplies, including Implanon, IUD, oral contraceptives and emergency contraceptives. Education, counseling (including contraceptive method and STI/HIV counseling), lab testing, and management are recommended.

6. Prescription medication coverage as practiced by TennCare including medication management services is recommended.

End of John J. Dreyzehner, MD, MPH, FACOEM

Commissioner's Comment

State of Tennessee

Department of Commerce and Insurance

Mike Moser,

Company/Organization Not Supplied

As you know, or should know, prescription drug abuse is at an all time high and has its affect on many facets of government, from the court system to hospitals (usually, uninsured emergency room visits) to health departments, housing, to the need for foster parents to take in babies born with drug abuse addictions from the mom, etc.

I see this every day covering as a reporter the court system. I am not sure how feasible this is, but I think it would help many state agencies if thought was given to the creation of an intensive, in- house drug rehab facility that the court system, DCS, etc, can order those with prescription (and other addictions) to so they can recover and become contributing members of society. The facility would not only need to address addiction, but life skills and even education toward gainful employment once an addict is "cleaned."

I realize there are several religious and private rehab programs out there, but most addicts do not have a religious base and are not interested in that, most do not have insurance that would pay for such treatment, and most won't voluntarily go. A state facility that the courts could mandate attendance to would be a step in the right direction toward addressing many of our problems.

End of Mike Moser's Comment

State of Tennessee

Department of Commerce and Insurance

Sarah Sullivan, MS, RD, LDN,

Tennessee Academy of Nutrition and Dietetics

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

I have been a registered dietitian for three years and have spent most of that time working with patients who have disorders primarily treated by diet. I have served my profession on the local, state and national level in helping improve the health of our population. Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

Overweight and obesity, along with all its comorbidities, is one of the largest public health issues facing our country and our state. According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition, specifically medical nutrition therapy. [1] RDs tackle these in a coordinated and cost effective manner. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." [2] A Registered Dietitian requires an advanced degree with a dietetic internship. We are well trained to meet the challenges of the nutritional needs of our patients.

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. [3] Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.

Registered dietitians can help each resident take responsibility for their health in creating healthier individuals who in turn require less of our healthcare dollars. Please do not hesitate to contact me at sarahsullivan2011@gmail.com with any questions or requests for additional information. I can make myself available to you as a resource and will do anything I can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens.

End of Sarah Sullivan, MS, RD, LDN's Comment

State of Tennessee

Department of Commerce and Insurance

John C. Osborn, D.D.S.,

President,

Tennessee Dental Association

First, I want to thank you for the opportunity to share the Tennessee Dental Association's (TDA) thoughts regarding the Healthcare Exchanges in order to assist the Department of Commerce and Insurance as we navigate through this most complex endeavor.

The Tennessee Essential Health Benefits grid, I am confident, required extensive time and resources to produce, but it is extremely valuable when comparing plans as we discuss dental services required by the federal mandate for children.

At this early stage in the development of the Healthcare Exchanges, it is not our intent to address specific details but rather highlight certain tenets common to nearly all dental benefit plans both in Tennessee and throughout the nation.

As was evident in the early days of TennCare, dental benefits tend to be ignored when bundled with medical services. For this reason, we recommend that freestanding dental benefit companies or medical insurance companies offering a dental benefit do so as freestanding additions to their medical plans.

There are, however, two major exceptions to the norm when dental and medical procedures are completely separate. The first is the medically necessary extraction of wisdom teeth and the second is general anesthesia provided to children 8-years-old and younger when undergoing dental procedures that cannot be accomplished without the benefit of anesthesia.

Dental benefits should be paid on a fee-for-service basis as capitation dental benefit plans offered in Tennessee to date have failed miserably since most dentists have historically not participated.

Ms. Chlora Lindley-Meyers Page 2 August 10, 2012

Any dental benefits offered through the Healthcare Exchanges should emphasize prevention by paying 100% for such benefits, and the dental services made available to the children should be comprehensive in nature.

Also, dentists should be adequately reimbursed for covered services provided.

As noted above, I am not attempting to be too specific or comprehensive today. That said, we also have questions for which the insurers (dental benefit companies) will need answers soon:

- *What is the maximum age of a child as defined by the Act?*
- *Will dental benefits have an annual or lifetime maximum?*
- *How will the dental benefit change based upon the Exchange level purchased?*
- *Can dental benefits (other than preventive services) be subject to a deductible?*

While there are many additional subjects to be discussed and details to be determined, I am confident that you will take into serious consideration these initial comments and invite the TDA to participate in further discussions.

The TDA has had access to dental care for all Tennesseans as its primary focus for several years now. Our Association believes that the Healthcare Insurance Exchanges, if well designed, will help to enhance the welfare of many of our

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

citizens who now seek access but cannot afford quality dental care. I understand that balancing the cost and benefits of the Healthcare Insurance Exchanges is an extremely difficult task.

Once again, thank you for the opportunity to participate in the Healthcare Exchange design process.

End of John C. Osborn, D.D.S.,

President's Comment

State of Tennessee

Department of Commerce and Insurance

Kristin Dugger, MS, RD, LDN

Clinical Dietitian

Tri-Cities Academy of Nutrition & Dietetics, President

Tennessee Academy of Nutrition & Dietetics, Public Policy Coordinator,
Company/Organization Not Supplied

I am writing to you as a concerned citizen/Registered Dietitian and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

I am a Tennessee citizen and I am very proud of my state and its volunteer heritage. I have also been a registered dietitian for three years and I spend most my days providing accurate, evidenced-based nutrition information to rehabilitation patients and I volunteer to provide access to the same nutrition information for my community. I serve my profession on the local, state and national level promoting nutrition services for the public. Our health care system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize medical nutrition therapy/nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides this coverage.

In my opinion, including nutrition services in the Essential Health Benefits package - section 1302(b)(1) requires items and services be provided in ten categories. Nutrition Services - specifically Medical Nutrition Therapy would be an incredible benefit for our citizens under the 9th category of preventative and wellness services and chronic disease management and it will assist Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save a lot of health care dollars by preventing or delaying the onset of many disease or helping to manage chronic disease states including but not limited to diabetes mellitus, obesity, cancer, cardiac disease, kidney disease, stroke, etc. I know part of the written comment period is to obtain information on what insurance companies are currently providing - not many insurance companies are covering medical nutrition services in Tennessee which is a huge disservice to our state. Recently Wal-Mart started covering nutrition services - Wal-Mart Employee Health Benefits Cover Nutrition Services as yet another example of how the Patient Protection and Affordable Care Act ("health reform") has expanded coverage for nutrition services, Wal-Mart's employee health plan includes coverage for nutrition counseling for adults with known risk factors for cardiovascular and diet-related chronic disease and obesity counseling.

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults.[1] According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's health care challenges present an opportunity to not only impact the amount of money spent on health care, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers.[2] Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

RDs are the most cost-effective, qualified health care professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[3]

Registered Dietitians require an advanced degree from a credentialed program followed by a dietetic internship. We are required to take a national registration exam and are credentialed by a third party. In Tennessee we are also required in many areas to have a professional license. We are well trained to meet the challenges of the nutritional needs of our patients. Please see the top ten reasons to consult a dietitian below. Much like other professionals like physical therapists, occupational therapists, and speech therapists - Registered Dietitians should be accessible to patients who are referred by physicians. Currently many patients are having to pay substantial fees out of pocket to receive medical nutrition therapy.

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.[4]

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care.[5] *Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.*[6]

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

With the multitude of scams and quick diet fixes available through the Internet, many of our citizens are misinformed about nutrition, especially since nutrition science is ever changing necessitating professionals who can analyze and interpret information appropriately. Registered dietitians are well grounded in evidence-based practice and are specifically trained in how to reach patients in changing their diets; but the profession has long been without the opportunity to impact significant change because of the lack of reimbursement. Registered dietitian services are cost effective and our team efforts have the potential to help the medical and allied professions address nutrition issues.

Just to bring home the point, can you imagine going into a medical center and being diagnosed with a mental disorder? Your physician orders a consult with a psychologist or a psychiatrist who then comes to you in that setting and educates you about your specific mental disorder and sends you on your way without follow-up. In many cases, nutrition services works in this fashion. Registered dietitians do not have the chance to make more of an impact because of the lack of opportunity. What, if on the other hand, you could see that dietitian as an outpatient in an office with an affordable co-pay and those sessions decrease your health risk, prevent or delay the onset of a chronic disease, or helps to manage

State of Tennessee

Department of Commerce and Insurance

your current disease – decreasing the number of doctors visits and medication needed! What seems very obvious to those of us, who are in the field, would mean a significant cost savings for Tennessee and Tennesseans.

When Governor Haslam ran for Governor, he emphasized the need for all of us to take on personal responsibility. Registered dietitians can help in this area, creating healthier individuals who in turn require less of our health care dollars. Please do not hesitate to contact me at 423-952-1752 or by email at kristin.dugger@gmail.com with any questions or requests for additional information. I can make myself available to you as a resource and will do anything I can to help communicate what our profession has to offer to better meet the health care needs of Tennessee's citizens.

End of Kristin Dugger, MS, RD, LDN

Clinical Dietitian

Tri-Cities Academy of Nutrition & Dietetics, President

Tennessee Academy of Nutrition & Dietetics, Public Policy Coordinator's Comment

State of Tennessee

Department of Commerce and Insurance

Jeremy Van Haselen

Vice President, State Government Affairs,
DaVita

DaVita appreciates the opportunity to provide comments regarding Tennessee's current process for determining its Essential Health Benefit (EHB) benchmark plan and related issues. The DaVita patient population includes more than 145,000 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services.

Spanning 44 States and the District of Columbia, the DaVita network includes more than 1,800 locations. DaVita's nationwide network is staffed by 45,000 teammates (employees). In addition to the 722 teammates in our Brentwood business office, DaVita has the privilege of providing dialysis treatment for over 1,998 individuals with kidney failure throughout our 41 centers across Tennessee.

Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

Background

ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys stop fully functioning and, therefore, cannot sustain life. When one's kidneys fail that individual requires either a transplant or regular dialysis treatment; traditional incenter dialysis is generally performed at least three times a week for about four hours each session. Also of importance is the fact that, under federal law, individuals who are medically determined to have ESRD may apply for Medicare benefits.

The concerns expressed in this letter focus on the following three items: (1) choosing Tennessee's EHB benchmark option, (2) clarifying prohibitions on qualified health plan (QHP) discrimination of patients with significant health needs, and (3) allowing individuals with ESRD to access exchange-subsidized coverage.

1. Choosing Tennessee's EHB Benchmark Option

DaVita greatly appreciates the opportunity to comment on our preferred benchmark plan option. Of the benchmark plan options delineated by Tennessee's Department of Commerce and Insurance, all would be acceptable based on the explicit coverage of dialysis, adequate patient protections and other factors,

State of Tennessee

Department of Commerce and Insurance

with one exception. DaVita does not find to be acceptable the out-of-network policies contained within the Blue Cross Blue Shield Basic Federal Employee health plan. It is our experience that this plan has out of network benefits that are very restrictive for dialysis beneficiaries. Beneficiaries pay premiums to enjoy the freedom that comes with accessing the health care provider of their choice, be they in-network

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or out. This is especially true of individuals requiring dialysis a minimum of three times a week.

Tennessee's benchmark plan should ensure Tennesseans requiring dialysis have a viable option for out of network care and accordingly we strongly urge against the State of Tennessee choosing the BCBS Basic Federal Employee plan.

2. Clarify Prohibitions on Qualified Health Plan Discrimination of Patients with Significant Health Needs

Proper benefit design is a critical aspect for consideration as CCIIO continues to promulgate regulations relating to EHBs. This is especially true in the case of individuals with significant health needs, like those with kidney failure. As noted above, patients with ESRD often require in-center dialysis at least three times per week for about four hours each session. Without the benefit of a kidney transplant, ESRD patients can require dialysis for the entirety of their lives. As such, without proper protections, health plans may be incentivized to design plans that encourage patients with significant health needs to drop their exchange insurance and move to other sources of coverage (such as Medicare in the case of individuals who are diagnosed with ESRD). Not only would this be a significant disruption for these individuals and their families, but if such patients "spend down" their assets sufficiently to pay the 20% coinsurance amount that Medicare does not cover, these individuals could become dually-eligible for Medicare and Medicaid, meaning Tennessee's Medicaid budget would be negatively impacted.

As you know, the ACA and subsequent regulations prohibit QHP benefit designs that have the effect of discouraging enrollment by higher-need individuals.¹ However, such discriminatory practices and the means to address such practices are not well-defined. EHB guidance released by CCIIO in December 2011 and additional guidance released in February 2012 raise concerns that upcoming EHB regulations,

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

in fact, could explicitly allow plan designs that discourage enrollment by individuals with significant health needs.² For example, the February 2012 EHB FAQ specifically allows for scope and duration limits.³ A March 2012 cost-sharing bulletin appears to allow for variations in cost-sharing on particular benefits or providers.⁴ Although these bulletins note that such variations are subject to nondiscrimination requirements, these requirements are not well-defined.

The December 2011 EHB bulletin indicated that CCIIO intends to propose that EHBs be defined by a benchmark plan selected by each state. Under such a policy, we would respectfully request the Tennessee Department of Commerce and Insurance urge CCIIO to satisfy the ACA's QHP benefit designs requirements by further clarifying that QHPs be prohibited from employing benefit designs for individuals with significant health needs that include limits on scope, duration, costsharing or network adequacy beyond those limits already included in a state's chosen benchmark plan. This additional clarification to the ACA's QHP benefit design requirement should provide additional protection to vulnerable patient populations, protect Tennessee's Medicaid budget from additional costs and ease the burden for Tennessee's enforcement of the ACA's QHP benefit design requirements.

3. Allow Individuals with ESRD to Access Exchange-subsidized Coverage

Although not directly related to EHBs, we also would highlight here our strong preference that the Internal Revenue Service (IRS) ensure that ESRD patients have the right to choose between subsidized

1 § 1311(c)(1)(A) of the ACA; 45 CFR 156.225

2 Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, 16 December 2011.

3 Center for Consumer Information and Insurance Oversight, Frequently Asked Questions on Essential Health Benefits Bulletin, 17 February 2012.

4 Center for Consumer Information and Insurance Oversight, Actuarial Value and Cost-Sharing Reductions Bulletin, 24 February 2012.

exchange coverage and Medicare coverage. As you know, the ACA provides new premium credits and cost-sharing subsidies for the purchase of individual coverage in an exchange, but disallows such assistance for individuals with other "minimum essential coverage," including Medicare Part A.⁵

Allowing individuals to choose subsidized exchange coverage is critical because otherwise individuals with ESRD would be forced to leave an exchange simply because of their diagnosis. Unfortunately, in

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

the exchange subsidy regulation published in the Federal Register on May 23, 2012⁶, the IRS sets forth new regulations⁷ which appear to disallow an individual with ESRD from choosing to not apply for Medicare benefits and, thereby, retain their subsidized exchange coverage. This is notwithstanding the fact that patients with ESRD must apply for Medicare benefits under the Medicare statute.⁸

Under the exchange subsidy regulation, it appears likely that, over time, a growing percentage of exchange members who are able to purchase affordable coverage through an exchange as a result of ACA subsidies will be disenfranchised from those subsidies once they develop ESRD. Such a dynamic also could negatively affect state Medicaid budgets. This is due to the fact that many ESRD patients without private coverage become dually eligible for both Medicare and Medicaid due to the high costs of coinsurance and other out-of-pocket expenses associated with their care. If patients cannot access their private plans, these patients will spend down their assets sooner and enter state Medicaid programs prematurely. In Tennessee, independent estimates show this could result in \$29M in additional state and federal Medicaid spending over 7 years (2014-2021). Fortunately, the exchange subsidy regulation also notes that “the IRS and the Treasury Department expect to publish additional guidance clarifying when or if an individual becomes ‘eligible for government-sponsored minimum essential coverage’ when the eligibility for that coverage is a result of a particular illness or condition.”⁹ For all the reasons stated above, we respectfully request the Tennessee Department of Commerce and Insurance urge the IRS to clarify in forthcoming guidance that those individuals with exchange-subsidized coverage who subsequently develop ESRD may remain eligible for exchange-subsidized coverage.

I appreciate the opportunity to share my comments and recommendations with you.

Please do not hesitate to contact me at jeremy.vanhaselen@davita.com if you would like to discuss these recommendations in detail or have any questions.

End of Jeremy Van Haselen

Vice President, State Government Affairs

's Comment

State of Tennessee

Department of Commerce and Insurance

Abbie Derrick Kozomara, MS, RD, LDN

President,

Tennessee Academy of Nutrition and Dietetics

The Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association) is committed to improving the health of the citizens of our state. We recognize the important work underway in Tennessee to create the state health insurance exchange and define the benefits and coverage to be afforded to our citizens. As the essential health benefits package is being designed, we believe it should include access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

We believe we have an opportunity to help our state save significant healthcare dollars as Tennessee decision makers make the most cost effective decisions for Tennessee citizens. In fact, we believe that we have an opportunity to be a national leader in these efforts and, again, demonstrate our ability in Tennessee to showcase an innovative way to address a significant national need. It is indeed exciting to know that what registered dietitians have to offer helps Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults.[1] According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death, including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers.[2] Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

Registered dietitians are the most cost-effective, qualified healthcare professional to provide MNT. Medical nutrition therapy is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." [3]

Medical nutrition therapy provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. Registered dietitians provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.[4]

State of Tennessee

Department of Commerce and Insurance

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. Medical nutrition therapy provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care.[5] Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.[6]

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. Registered dietitians are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

Please do not hesitate to contact me at 615-210-6289 or by email at cu_tiger_lily@yahoo.com with any questions or requests for additional information. The Tennessee Academy of Nutrition and Dietetics is available to you as a resource and we will do anything we can to help communicate what our profession has to offer to better meet the healthcare needs of Tennessee's citizens. When Governor Haslam ran for Governor, he emphasized the need for all of us to take on personal responsibility. Registered dietitians can help in this area, creating healthier individuals who in turn require less of our healthcare dollars.

End of Abbie Derrick Kozomara, MS, RD, LDN

President's Comment

State of Tennessee

Department of Commerce and Insurance

Jeanne Gore,

Company/Organization Not Supplied

I write to request full coverage of all medicines, psychiatric visits, and hospital stays as the bare bones minimum for those of our state who face mood disorders and metal illness. For some, affordable housing and job placement are major needs.

If our citizens suffer without help from such disorders and brain illnesses, the cost to us as a society is more than we can afford.

End of Jeanne Gore's Comment

State of Tennessee

Department of Commerce and Insurance

Blair Mize, MS, RD

Inpatient Transplant Clinical Dietitian,

Methodist University Hospital

I believe licensed registered dietitians should be included in the Essential Health Benefits law. As you know, obesity is at an all-time high in Tennessee and the US. Obesity leads to hypertension, diabetes, back and knee pain and surgeries, depression, heart disease and a host of other complications. Obesity in TN and the US is costing millions of dollars in health care complications.

Registered dietitians have the expertise to address obesity. They not only have the knowledge of the body and how food is digested and metabolized, but have the knowledge of diets and disease. They are able to assist clients in making gradual change in their eating patterns, while addressing such things as diabetes, so that they can eventually lose weight and be healthier.

Additionally, obesity in children is very high in TN. Overweight children are more likely to become overweight adults and thus face complications. In fact, obese children have been found to have high cholesterol and heart disease. The Dietetic Internships in TN, of which there are 7, are working collaboratively to provide nutrition instruction to children and parents in order to prevent or reverse obesity in childhood. Nutrition instruction at an early age has proved to be beneficial.

Our state, and you as a committee/lawmaker, need to do everything within our power to stop this obesity trend. Registered Dietitians are the experts and are willing to help, so please include us in the Essential Health Benefits.

End of Blair Mize, MS, RD

Inpatient Transplant Clinical Dietitian

's Comment

State of Tennessee

Department of Commerce and Insurance

Jonathan Ray,

Tennessee State Chapter of the American Society for Metabolic and Bariatric Surgery

In the coming weeks, the State of Tennessee will move forward in selecting a benchmark health plan to define the scope of its essential health benefits package for its health exchange plan. At this critical juncture, the Tennessee State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), and its many members providing obesity treatment services across the state, implore you to recognize our country's rising obesity epidemic and the importance of ensuring patient access to medically necessary treatment services for the medical and surgical management of obesity.

Specifically, we are recommending that the State adopt either of the Tennessee State Employee plans (Partnership PPO or Standard PPO) as the model for the essential benefit program as it covers at least some of the services to treat obesity (healthy diet counseling and bariatric and metabolic surgery). In addition, we are recommending that the State carefully review services required by the Affordable Care Act (such as intensive obesity counseling as it has a B rating from the USPTF) to make sure they have been added, as required. Finally, we recommend that a process for adding "new" essential benefits be developed quickly as new, safe and effective obesity treatments, such as obesity drugs, either have been or will be approved and will soon be available to citizens of Tennessee.

Obesity's impact on both individual health as well as healthcare costs is well documented. Many large employers, federal programs, such as Medicare, Tricare and the Federal Employees Health Benefits Plan as well as State plans, such as state employee and TennCare, provide coverage for various obesity treatment services as they recognize both the health improvement as well as cost-savings benefit of such coverage.

Unfortunately, this philosophy has not translated down to the small employer and individual markets regarding the fundamental obesity treatment tools – intensive behavioral counseling, pharmacotherapy and bariatric surgery as it appears that private insurers have placed short-term profits and/or concerns about adverse selection above the health of their members as well as their long-term bottom line.

Bariatric and Metabolic Surgery Coverage

We would like to note that Medicare, Tricare, 47 State Medicaid plans and 44 State employee plans cover bariatric and metabolic surgery. In addition, Mercer's 2010 National Survey of Employer-Sponsored Health Plans show that bariatric surgery is covered by 40% of plans with <500 employees AND also that the fastest growth in coverage is in small employers (<500) which is growing at 8% annually.

In evaluating coverage of bariatric surgery, we noticed a trend similar to the one outlined above in the Mercer data. For example, virtually all of the benchmark plans under consideration provide coverage for bariatric and metabolic surgery with the exception of the three plans that fall within the "largest small group plans" category.

State of Tennessee

Department of Commerce and Insurance

Too often, for too long, private health plans have excluded coverage for obesity treatment services -- partly due to shortsighted cost savings efforts and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

Obesity treatments, like metabolic and bariatric surgery and behavior modification programs, help resolve comorbidities, reduce costs, and transform the lives of patients. In fact, bariatric and metabolic surgery can resolve or improve diabetes (78.1% resolved, 86.6% improved or resolved) and other obesity – related comorbidities after metabolic and bariatric surgery. In addition, bariatric and metabolic surgery is highly cost effective producing longitudinal cost savings and overall health improvement. The downstream savings associated with metabolic surgery procedures is approximately 2 years, with a range of 16 to 34 months.

Just like many other serious medical conditions, obesity is a complex, multifactorial chronic disease, which requires a multidisciplinary treatment approach. This approach must encompass the best standards of care, both in terms of the treatments chosen and the clinical environment in which they are delivered. Such treatments should be reimbursed as any other disease therapy would be.

As the state moves forward in choosing an appropriate benchmark plan, the Tennessee State Chapter of the ASMBS urges state policymakers to recognize that obesity is a serious chronic disease and deserves to be treated with respect in the same fashion as diabetes, heart disease or cancer. Therefore, when crafting the benefit plan, please afford those affected by obesity with the same medically necessary treatment avenues afforded to all others who suffer from chronic disease.

End of Jonathan Ray's Comment

State of Tennessee

Department of Commerce and Insurance

Name Not Supplied,

Tennessee Association of Nurse Anesthetists

On behalf of the Tennessee Association of Nurse Anesthetists (TANA), thank you for the opportunity to provide comments on the determination of an essential health benefits package for health insurance coverage under the federal Patient Protection and Affordable Care Act (ACA). TANA represents more than 1900 members who provide safe and cost-effective healthcare services to patients in both rural and urban areas across the state.

Certified Registered Nurse Anesthetists (CRNAs) are advanced practice nurses who personally administer more than 32 million anesthetics given to patients each year in the United States, according to the 2010 AANA Practice Profile Survey. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals.

TANA raises the following points for your consideration:

1) Require Practice of Anesthesia and Analgesia Care Provided by CRNAs be Included as an Essential Health Benefit. CRNAs are an important type of provider with an integral role in providing anesthesia and analgesia-related care, including pain management services. CRNAs have provided anesthesia in the U.S. for nearly 150 years, and high quality, cost effective CRNA services continue to be in high demand. These services provided by trained and qualified health care providers, such as CRNAs, are essential in patient care.

We believe the practice of anesthesia and analgesia care provided by CRNAs fits under many of the services listed in Section 1302(b)(1) of the ACA as essential health benefits. CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, all types of specialty surgeons, and pain management specialists. Furthermore, CRNAs are the primary anesthesia professionals in rural communities and other medically underserved areas of the United States. Since the ACA describes "essential services" for qualified health plans participating in state exchanges to include hospitalization, ambulatory patient services, emergency services, and maternity care, we interpret those essential services to include anesthesia and analgesia services for surgical and diagnostic procedures and interventional pain management services provided by CRNAs. As HHS is initiating the regulatory approach that will eventually define EHBs, and because anesthesia and analgesia care given by CRNAs fits into many of the essential health benefits requirements in the ACA, we request that the department require in the proposed essential health benefits rule that anesthesia services be included expressly among the ten categories of essential services in the ACA.

2) Permit CRNAs to Have Full Voting Representation on Exchange Governing Boards. TANA believes qualified licensed healthcare non-physician providers who bill for Medicare Part B services, such as CRNAs, should be included as members with full voting representation on Exchange governing boards. This will help achieve the goal of ensuring that Exchange boards as a whole have the necessary technical expertise to ensure successful operations. This also ensures that patients' interests are well represented in Exchanges as this would help increase patient choice of providers and access to care, both of which are principle components of the Affordable Care Act. We, therefore, recommend that qualified licensed

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

healthcare non-physician providers who bill for Medicare Part B services, such as CRNAs, should be included as members with full voting representation on Exchange governing boards. Additional groups will provide diverse input and will ensure the viewpoints of the various groups impacted by the Exchange will be represented.

3) Require Exchanges and Qualified Health Plans Participating in State and Federal Facilitated Exchanges to Align their Payment Systems to Comply with State and Federal Non-Discrimination Provisions. In today's delivery system, health plans may discriminate against whole classes of healthcare professionals based solely on their licensure or certification. This can limit or deny patient choice and access to a range of beneficial, safe and cost-efficient healthcare professionals. Such discrimination is not only wrong in principle, but also limits or even denies patient choice and access to a range of providers and in general, results in a less than ideal and suboptimal delivery system. Therefore, we urge Tennessee to adhere to existing state provider non-discrimination laws. Further, to better ensure patients receive access to high-quality, cost-effective care, we also recommend requiring Exchanges, and qualified health plans operating in Exchanges, to adhere to the federal provider non-discrimination provision in the Affordable Care Act (ACA) (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706, "Non-Discrimination in Health Care, 42 USC §300gg-5) slated to take effect January 1, 2014. Ensuring that providers are not discriminated against in this fashion would help encourage the placement and location of skilled healthcare professionals in those areas currently without a sufficient numbers of providers to adequately serve the public.

4) Require Non-Physician Providers Who Bill For Medicare Part B be Included in Group of Providers Who Consult with Exchanges. Health care delivery hinges on the services of millions of non-physician providers. As such, states should look beyond the advice of physicians solely in determining and evaluating the appropriate operations of Exchanges. Qualified licensed healthcare professionals, such as non-physician providers who bill for Part B services under Medicare, should be included in the group of health care providers who consult with the development and operation of Exchanges.

For example, in rural communities and other medically underserved areas of the United States, CRNAs are the primary anesthesia professionals. Their presence enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who might otherwise be forced to travel long distances for these essential care. Thus, the TANA recommends that qualified licensed healthcare professionals, such as non-physician providers who bill for Part B services under Medicare, be included in the group of health care providers who consult with the development and operation of Exchanges.

5) Require CRNAs and other Non-Physician Providers Who Bill For Medicare Part B be Included in Health Plans Offering Essential Health Benefits. CRNAs provide safe, high-quality and cost effective anesthesia care. Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of Nursing Economic\$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model. Furthermore, an August 2010 study published in Health Affairs shows no differences inpatient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.

State of Tennessee

Department of Commerce and Insurance

*We, therefore, believe that in order to ensure access to necessary anesthesia and analgesia services, health plans offering essential health benefits should include CRNA services. We request that CRNAs and other non-physician providers who bill for Medicare Part B be included in health plans offering essential health benefits. Furthermore, CRNAs should be recognized as providers who are eligible for direct reimbursement in these health plans and their networks. Doing so would ensure that these plans include a sufficient choice of providers who provide increased access to high quality and cost-effective care, and promote competition and choice. Such a recommendation is also consistent with the recent findings and recommendations of the Institute of Medicine, whose report titled *The Future of Nursing: Leading Change, Advancing Health* calls for removing barriers so that advanced practice registered nurses (APRNs), including CRNAs, can practice to the full extent of their education and training, indicating that APRNs play a critical role in the future of health care.*

6) Require CRNAs to be Included in Qualified Health Plan Provider Networks and Require QHPs to Adhere to the ACA's Provider Nondiscrimination Provision. CRNAs are an important type of provider with an integral role in providing anesthesia and analgesia-related care, including pain management services. They provide safe, high-quality and cost effective anesthesia care and are advanced practice registered nurses who personally administer about 32 million anesthetics to patients each year. In addition, the establishment of state-based exchanges today is contingent upon other provisions of the ACA slated to take effect in the future. For example, as the department prepares to implement the provider nondiscrimination provision in the ACA mentioned above, we anticipate CRNAs ought to be expressly recognized as eligible professionals in state exchanges and included in qualified health plans' networks. In delineating QHP requirements with regard to network adequacy, we believe that QHPs should adhere to the federal provider non-discrimination provision in the ACA mentioned above. Without strong patient access safeguards in place, we are concerned that lax network adequacy standards could limit the number of providers or the types of providers on their panels, which could severely limit patient access to needed care. To prevent this, we believe it is critical that Exchanges and QHPs are aware of and are fully complying with this federal provision.

If you have questions or need additional information. Please do not hesitate to contact our lobbyist, Tausha Alexander at tausha@alexandergr.com. Thank you for your time and consideration.

End of Name Not Supplied's Comment

State of Tennessee

Department of Commerce and Insurance

Roger Stewart

Interim Executive Director,

NAMI Tennessee (National Alliance on Mental Illness)

On behalf of over 380,000 Tennesseans living with serious mental illness, and their families, I appreciate the opportunity to submit comments on selection of a benchmark plan to establish essential health benefits for the Tennessee Health Insurance Exchange. The Patient Protection and Affordable Care Act (ACA) requires mental health treatment within ten categories of essential health benefits including behavioral health. Further, Qualified Health Plans in the State Insurance Exchange must comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) for individual and employer sponsored plans regardless of number of employees.

Continuity with TennCare

NAMI Tennessee recommends that Tennessee Health Insurance Exchange package include mental health and substance abuse benefits on par with the TennCare program in recognition of the vital necessity for continuity of care to support recovery and economic self-sufficiency. When the transition between TennCare and Exchange plans can be negotiated without disruption of care, TennCare enrollees with mental health conditions will be more likely to enter the job market based on the ability to continue pursuing their recovery, hence their ability to succeed in the workplace.

Alternative Benchmark FEHP

If TennCare is not chosen as a benchmark, NAMI supports selection of a Federal Employee Benefits Plan, standard option. Federal Employee Benefits Plans have been subject to parity requirements since 2001 and have a long track record of effectiveness in terms of care outcomes and cost effectiveness.

Wrap-Around Service Capacity

If the chosen benchmark plan does not include the complete array of TennCare mental health services, NAMI recommends provision to facilitate publicly funded care to supplement gaps in the array of core services necessary to support recovery. Individuals with serious mental illness who are enrollees in Exchange plans, whether through the individual or SHOP market, should continue to be eligible for wrap-around services funded with public dollars. Examples of care include, but are not limited to supported housing, supported employment and peer support.

Emergency Care

Given that emergency services are among the ten categories of required essential health benefits and the requirement for all Exchange plans to comply with MHPAEA requirements, psychiatric crisis response should be required in the health insurance exchange benefit on par with emergency response services for other domains of care.

Prescription Drugs

Individualized access to medications is vital to effective management of psychiatric conditions. Because patients respond differently to different psychiatric medications it can often take several trials and many months to find an appropriate drug regimen to stabilize an individual's condition. For people with serious and persistent mental illness or those suffering from co-morbid conditions, providers must be able to select from a full range of drug options so as to maximize treatment adherence and effectiveness, minimize side effects and avoid drug-to-drug interactions. For these reasons, NAMI recommends adoption of provisions for six protected classes, based on the Medicare Part D drug program including anticonvulsants, antidepressants and antipsychotics. In addition, prior authorization requirements and other utilization controls should be limited to ensure access by physicians and their patients to the appropriate standard of care. NAMI

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

strongly supports evidence-based treatment. However, because of the need to maintain flexibility in treatment to accommodate individual response to medications and because of the lengthy, complicated process necessary to establish FDA approval for use of a particular agent for a specific condition, NAMI opposes prohibitions on off-label prescriptions.

Collaboration with Department of Mental Health and Substance Abuse Services

Finally, in order to promote optimal health for Tennesseans, key stakeholders such as Commissioner Varney (Department of Mental Health and Substance Abuse Services), Commissioner Henry (Department of Intellectual and Developmental Disabilities), and Commissioner Dreyzehner (Department of Health) should be involved in a more granular assessment of benefits, their terms and conditions prior to submission of recommendations to Governor Haslam.

End of Roger Stewart

Interim Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

Martha Dixon, RD,

Tennessee Academy of Nutrition and Dietetics

I am writing to you as a concerned citizen and as a member of the Tennessee Academy of Nutrition and Dietetics (formerly the Tennessee Dietetic Association). I urge the state health insurance exchanges to consider access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs).

Our healthcare system has been spotty at best in its coverage of nutrition services. Currently the Centers for Medicare and Medicaid recognize nutrition counseling for patients with diabetes and kidney disease which is helpful, but not all insurance provides coverage. In my opinion, including nutrition services will assist Governor Haslam's efforts to provide conservative fiscal leadership in that nutrition services save healthcare dollars.

In fact, I sincerely believe we have an opportunity to be a national leader in these efforts and, again, demonstrate our ability in Tennessee to showcase an innovative way to address a significant national need.

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and morbid obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of death of adults.[1] According to the Centers for Disease Control, Tennessee's obesity rates are among the highest in the nation with greater than 30% of our population considered morbidly obese. A report by Trust for America's Health states \$30 billion could be saved in the United States over five years if obesity rates in America were reduced by just five percent. Although the exact figure for Tennessee is not known, since Tennessee has one of the highest obesity rates in the nation, there is no question that Tennessee's healthcare challenges present an opportunity to not only impact the amount of money spent on healthcare, but also improve the quality of life for its citizens.

In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers.[2] Four of the top six leading causes of death, including diseases of the heart, cancer, cerebrovascular disease and diabetes, can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." [3] You may not know, but to practice MNT, a Registered Dietitian requires an advanced degree with a dietetic internship. We are well trained to meet the challenges of the nutritional needs of our patients.

MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.[4]

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity. MNT provided by RDs also impacts productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care.[5] Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.[6]

Given the observations that nutrition plays a role in managing chronic disease, it is evident that MNT be included in the essential health benefits for the Tennessee health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. By utilizing RDs to provide such services in conjunction with such services being covered by insurance carriers, there will be a significant impact on chronic disease and the resulting cost-savings.

With the multitude of scams and quick diet fixes available through the internet, many of our citizens are misinformed about nutrition, especially since nutrition science is ever changing necessitating professionals who can analyze and interpret information appropriately. Registered dietitians are well grounded in evidence-based practice and are specifically trained in how to reach patients in changing their diets; but the profession has long been without the opportunity to impact significant change because of the lack of reimbursement. Registered dietitian services are cost effective and our team efforts have the potential to help the medical and allied professions address nutrition issues.

Just to bring home the point, can you imagine going into a medical center and being diagnosed with mental disorder? Your physician orders a consult with a psychologist or a psychiatrist who then comes to you in that setting and educates you about your specific mental disorder and sends you on your way without follow-up. In many cases, nutrition services works in this fashion. Registered dietitians do not have the chance to make more of an impact because of the lack of opportunity. What, if on the other hand, you could see that dietitian as an outpatient in an office with an affordable co-pay and those sessions decrease your health risk! What seems very obvious to those of us, who are in the field, would mean a significant cost savings for Tennessee and Tennesseans.

When Governor Haslam ran for Governor, he emphasized the need for all of us to take on personal responsibility. Registered dietitians can help in this area, creating healthier individuals who in turn require less of our healthcare dollars.

End of Martha Dixon, RD's Comment

State of Tennessee

Department of Commerce and Insurance

Mary Nell Bryan

President, Children's Hospital Alliance of Tennessee

Leslie Ladd

Executive Director, March of Dimes, Tennessee Chapter,
Children's Hospital Alliance of Tennessee

and the Tennessee Chapter of the March of Dimes

Thank you very much for allowing our organization(s) to participate during this comment period. We owe deep thanks to the Children's Hospital Association - formerly known as the National Association of Children's Hospitals and Related Institutions, to the March of Dimes, and to the American Academy of Pediatrics. The Children's Hospital Alliance of Tennessee and the Tennessee Chapter of the March of Dimes offer the suggestions below based on the recommendations the above-cited organizations made in their letter of January 23, 2012 to Mr. Steve Larsen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. Remarks enclosed in quotation marks are drawn intact from that letter.

The Affordable Care Act directs that the care of children should be a priority. "Congress recognized that children need different services than adults. Children are still growing and developing so their 'capabilities, physiology, judgment, and responses to interventions constantly change and must be continuously monitored." An increasing number of children suffer from chronic conditions that affect their development and that require specific attention in order to generate, maintain, and restore age-appropriate functioning."

We believe the Essential Health Benefits are required to cover all medically necessary services for children and trust Tennessee's plan will do that. Specifically, "Congress directed the Secretary to consider in particular discrimination against children, children as a vulnerable group and the medical dependency children experience. These requirements are set forth at §§1302(b)(4)(B), (C), and (D).

Specific Concerns Regarding Services for Children

Preventive Health Care Services. Under Section 2713 of the Affordable Care Act, all non-grandfathered plans must cover a range of preventive health services for infants, children and adolescents without cost-sharing. The statute states that insurers must provide coverage for all services contained in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, immunizations recommended by the Advisory Committee on Immunization Practices, and services receiving a recommendation of "A" or "B" from the US Preventive Services Task Force."

If Tennessee chooses to refer to a current plan or plans as benchmarks, unless plans are specifically made to address the needs of children, they could be deprived of critically important preventive care, which might lead to devastating consequences. We urge that all of Section 2713 of the ACA be applied to any Tennessee plan."

Pediatric Services Including Oral and Vision Care. We hope that the Bulletin "will not lead to the interpretation that the tenth category of essential health benefits consists only of pediatric oral and vision care. We respectfully submit that the plain language of the Affordable Care Act requires setting forth a category of services using the following words to define that category: 'pediatric services, including oral and vision care' [emphasis added]. The statute does not limit pediatric services to include only oral and vision care. We believe it recognizes the importance of unique pediatric services such as developmental screening and services."

State of Tennessee

Department of Commerce and Insurance

Allowable Visits and Cost Sharing. We have some concerns regarding non-clinical limitations that could be included in benchmark plans, and in particular, limitations on allowable visits and cost sharing. We agree that limiting allowable visits based on non-clinical considerations is essentially a limitation on the benefit and that under the proposed structure, limits in the benchmark plan would appear to translate into limits in the EHB. This structure could be devastating for children with special health care needs who may need multiple habilitative service visits, or applied behavioral analysis. Unlike adults, children may need habilitative care, not only re-habilitative care. Plans listed in the Exchanges must take into account their needs based on the aforementioned sections of the statute. One other idea to consider would be for the state to refer to the existing SCHIP plan to satisfy the benchmark for children.

FEHBP deficiencies for medically necessary pediatric services. The Bulletin suggests that the benchmark plan should refer to FEHBP as an appropriate plan to which to add pediatric oral and vision services. We believe that this is not an appropriate option because the average FEHBP plan does not address the clinical needs of all children. Private insurance is designed for a healthy adult population, which results in strict coverage limits, including exclusion of most or all developmental disabilities. It is crucial that children's developmental needs are taken into account. We support coverage that follows Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines, tying medical need to children's individual conditions and providing coverage to ensure healthy child development.

EPSDT differs from the average FEBHP option in myriad ways. For example, EPSDT requires coverage of medically necessary services in relation to vision services such as eye exams and corrective lenses. Essential vision services to allow children to read the blackboard at school will not be available to children covered by Exchange plans if a plan similar to the average FEBHP Option is followed without changing the provisions for children.

As afore-mentioned, pediatric services under the statute are not limited to vision and oral services. Pediatric services that should be available to children under the tenth category of the EHB include other medically necessary services. For example, medically necessary services for developmental assessment should be covered as well as medically necessary services for anticipatory guidance, covering conditions identified through early intervention and child care programs, including, as needed, maintenance therapy, recreational and educational therapy, and related diagnostic testing. According to the plan comparison provided, it appears that the Partnership PPO and the Standard PPO (state employee plans) do not provide coverage of maintenance therapy.

With regard to hearing services, children need coverage of medically necessary services including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development. Of the benchmark plans under consideration, the HMO and state employee plans do not cover hearing aids for children.

Children need coverage of durable medical equipment (DME) when medically necessary, and children need access to medically necessary home nursing services such as home visits from health educators, therapists, health aides, and others.

Specific Concerns Regarding Services for Women

Preventive Health Care Services. As noted above, Section 2713 of the Affordable Care Act requires all non-grandfathered health plans to cover a range of preventive health care services with no cost-sharing. This includes a package of preventive health care services for women developed by the Institute of Medicine and promulgated by the U.S. Health Resources and Services Administration. The package ensures that all women covered by Exchange plans will have coverage for preventive health services such as preconception care, well woman visits, and perinatal care. We respectfully request that you cover this package of services. If a grandfathered plan is selected as a benchmark package, women could be denied access to these services, with potential short- and long-term health consequences for both themselves and their children.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Maternity and Newborn Care. Section 1302 of the Affordable Care Act lists “maternity and newborn care” as one of the EHB categories. Any benchmark plan selected by the state should include the full scope of maternity care (preconception, prenatal, labor and delivery, and postpartum), as recommended by the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. These services reflect the latest clinical evidence available regarding effective, appropriate care to ensure the best health outcomes for women and their newborn children.

PKU Treatment

Tennessee mandates health insurance coverage of phenylketonuria (PKU) treatment. There is no cure for children with PKU, but these children can be treated effectively with a special diet that must be started within the first six weeks of life. For infants, the diet consists of a special formula that is free of phenylalanine. Later, formula is supplemented with a diet that is low in phenylalanine. The cost of this dietary regimen can be substantial, upwards of \$10,000 per child per year. As PKU treatment is a state mandated benefit, the small group, HMO, and state employee plans cover this important treatment and we urge you to include coverage of it under the Exchange plans as well.

We deeply appreciate the opportunity to share our thoughts with you regarding this matter and look forward to working with you as you move forward with implementation of Tennessee's Essential Health Benefits under the Affordable Care Act. We are grateful for your thoughtful consideration of the needs of children and families.

End of Mary Nell Bryan

President, Children's Hospital Alliance of Tennessee

Leslie Ladd

Executive Director, March of Dimes, Tennessee Chapter's Comment

State of Tennessee

Department of Commerce and Insurance

Josephine B Totten, RD LD Med,

Company/Organization Not Supplied

I learned nutrition and food science in graduate school and became a Registered Dietitian so I could legitimately prepare foods for special diets. My success has been limited by life's circumstances.

In 2005 I put myself on a Gluten Free / Casein Free diet to learn the difficulty faced by parents wanting their children, especially those with learning issues and autism, to have these GF/CF (Gluten Free / Casein Free) meals and snacks. I felt I had time to commit to this goal.

Examples of the confusion with Gluten Free diets follows. Can you guess which of these products has no gluten: Campbell's Low Sodium Chicken broth, Kellogg's Corn Flakes, Silk Soy Milk, Blue Diamond Almond Milk, Morning Star (vegetarian) bacon strips, Chop House rice pilaf, Honey Baked Spiral cut Ham, Boars Head Beef Frankfurters, Miller Lite Beer, Wendy's French Fries, Chix fil A Waffle Fries, Welch's filled Strawberry licorice., Starburst fruit chews, Wolfgang Puck Organic Hearty Lentil & Vegetable soup.

Identifying gluten plus milk protein (casein) in foods was difficult. The scarcity of such products and the unpleasant tastes accompanying those foods were frustrating. Surprisingly I personally found relief on this diet from my "spells" of migraines with flu symptoms, lifelong sub clinical depression with a couple of acute episodes, adult acne treated with daily antibiotics, and Gastrointestinal abnormalities. It was a 22 year journey of symptoms and testing, including CAT scans of abdomen, colonoscopies, migraine medicines, antibiotics, nerve conduction tests, and "sorry, but I don't know what to diagnose with your symptoms" from my GI doctor before the discovery that I was Celiac as a result of this experiment of putting myself on the GF/CF diet. It healed me.

Celiac requires the Gluten Free diet for treatment and symptom relief, plus healing of the small intestine which surprisingly has as many nerves as one's brain. Celiac is an autoimmune disease and occurs in about 9-10% of the population. The average journey from symptoms to diagnosis is 11 years. There are no medicines to date to give a cure, only food intake to treat and heal the damage.

The diet is difficult. Casein (milk protein) and wheat (one of the gluten sources) are in almost every prepared food. It is easy to eat GF/CF (Gluten Free/ Casein Free) if an informed cook prepares one's meals, which I usually do. It is not typical in our present society to have all home cooked meals by a dietitian or trained cook. The quicker foods are prepared, and the cheaper they are to prepare or purchase, the more likely they are to have gluten. There needs to be an affordable way to teach everyone, rich and poor, how to maintain a gluten free diet and other special diets that are required for normal, functional health. Please include Registered Dietitians in the Essential Health Benefit Package.

Gluten Free products listed above are: Blue Diamond Almond Milk, Boars Head Beef Frankfurters, Chix fil A waffle fries, Starburst fruit chews, Wolfgang Puck Organic Hearty Lentil & Vegetable Soup.

The remaining products are not labeled gluten free and one professes to not test for gluten of their products, but they could be OK for Celiacs. I personally experienced 3 months of atypical symptoms while consuming that product. Once off the product, symptoms of severe leg swelling and unexplained fatigue disappeared in 2 days.

Thank you for your consideration of this request.

End of Josephine B Totten, RD LD Med's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Ruth Ann Wilson,

Company/Organization Not Supplied

JUST SAY NO. Do not bring National Health Care to Tennessee. Leave us Alone. The American Public did not want this "FORCED" Monstrosity and the Federal Government was told not to pursue this "FORCED" program. Yet, the powers that be will not STOP, but continue to try some "back door approach" to come to the State Level and "FORCE" we, the people.

I am not interested as a citizen of Tennessee that the Governor is setting us to participate in this travesty. This has to do with GRANTS and Arm twisting to "FORCE" Tennesseans into this wickedness. Will the Repub Governor Haslam "FORCE" us into compliance when Americans and many Tennesseans have voiced their objections against this National Health Care????

Where is the integrity of the of once proud Tennesseans to provide for themselves??? The information collected from Mr. Garrett's Cleveland meeting seemed to be from "organizations" who want a "piece of the Federal pie" that will only bring enslavement to our State from the Feds. The Griffin ladies seemed to be the only True Citizens speaking against this travesty, the others were representing organizations that only want to be in on the "take" should Governor Haslam surrender Tennessee to this mischief and debauchery.

Please put me down as opposing this UNCONSTITUTIONAL Shenanigan.

End of Ruth Ann Wilson's Comment

State of Tennessee

Department of Commerce and Insurance

Susan Veale

Executive Assistant,

Rural Health Association of Tennessee (RHAT)

Representatives from the Rural Health Association of Tennessee were present at the Knoxville and Jackson meetings and stated that we would like to see the inclusion of all essential health benefits that are currently in place with an emphasis on prevention of illness. We would also like to include telemedicine reimbursement in this mix.

To further the discussion: It is well-documented that rural residents in Tennessee, in general, earn less than their urban counterparts, that rural residents are less likely to have insurance and are more likely to suffer chronic diseases. We are concerned that the price of these insurance policies be affordable to our rural residents.

As the health exchange is established in Tennessee, it must be remembered that there is currently a shortage of primary care and specialty physicians across the state and this is predicted to worsen as more people gain insurance.

End of Susan Veale

Executive Assistant

's Comment

State of Tennessee

Department of Commerce and Insurance

Tiffany Stevens

Executive Director,

Tennessee Chiropractic Association

As stated, Blue Cross Blue Shield has been consistently the best insurance company for Chiropractic Physicians to work with over the years.

Patients have experienced good communication and assistance when issues arise and providers find that their online, phone, and overall service and benefits communication are efficient and exceed that of their peers.

In closing, Blue Cross Blue Shield would be our first choice of Tennessee Exchange providers.

End of Tiffany Stevens

Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

Douglas O. Olsen, MD, FACS

President,

Tennessee Chapter of the American Society for Metabolic and Bariatric Surgery

In the coming weeks, the State of Tennessee will move forward in selecting a benchmark health plan to define the scope of its essential health benefits package for its health exchange plan. At this critical juncture, the Tennessee State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), and its many members providing obesity treatment services across the state, implore you to recognize our country's rising obesity epidemic and the importance of ensuring patient access to medically necessary treatment services for the medical and surgical management of obesity.

Specifically, we are recommending that the State adopt either of the Tennessee State Employee plans (Partnership PPO or Standard PPO) as the model for the essential benefit program as it covers at least some of the services to treat obesity (healthy diet counseling and bariatric and metabolic surgery). In addition, we are recommending that the State carefully review services required by the Affordable Care Act (such as intensive obesity counseling as it has a B rating from the USPTF) to make sure they have been added, as required. Finally, we recommend that a process for adding "new" essential benefits be developed quickly as new, safe and effective obesity treatments, such as obesity drugs, either have been or will be approved and will soon be available to citizens of Tennessee.

Obesity's impact on both individual health as well as healthcare costs is well documented. Many large employers, federal programs, such as Medicare, Tricare and the Federal Employees Health Benefits Plan as well as State plans, such as state employee and TennCare, provide coverage for various obesity treatment services as they recognize both the health improvement as well as cost-savings benefit of such coverage.

Unfortunately, this philosophy has not translated down to the small employer and individual markets regarding the fundamental obesity treatment tools – intensive behavioral counseling, pharmacotherapy and bariatric surgery as it appears that private insurers have placed short-term profits and/or concerns about adverse selection above the health of their members as well and their long-term bottom line.

Bariatric and Metabolic Surgery Coverage

We would like to note that Medicare, Tricare, 47 State Medicaid plans and 44 State employee plans cover bariatric and metabolic surgery. In addition, Mercer's 2010 National Survey of Employer-Sponsored Health Plans show that bariatric surgery is covered by 40% of plans with <500 employees AND also that the fastest growth in coverage is in small employers (<500) which is growing at 8% annually.

In evaluating coverage of bariatric surgery, we noticed a trend similar to the one outlined above in the Mercer data. For example, virtually all of the benchmark plans under consideration provide coverage for bariatric and metabolic surgery with the exception of the three plans that fall within the "largest small group plans" category.

Too often, for too long, private health plans have excluded coverage for obesity treatment services -- partly due to shortsighted cost savings efforts and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

Obesity treatments, like metabolic and bariatric surgery and behavior modification programs, help resolve comorbidities, reduce costs, and transform the lives of patients. In fact, bariatric and metabolic surgery can resolve or improve diabetes (78.1% resolved, 86.6% improved or resolved) and other obesity – related comorbidities after metabolic and bariatric surgery. In addition, bariatric and metabolic surgery is highly cost effective producing longitudinal cost savings and

State of Tennessee

Department of Commerce and Insurance

overall health improvement. The downstream savings associated with metabolic surgery procedures is approximately 2 years, with a range of 16 to 34 months.

Just like many other serious medical conditions, obesity is a complex, multifactorial chronic disease, which requires a multidisciplinary treatment approach. This approach must encompass the best standards of care, both in terms of the treatments chosen and the clinical environment in which they are delivered. Such treatments should be reimbursed as any other disease therapy would be.

As the state moves forward in choosing an appropriate benchmark plan, the Tennessee State Chapter of the ASMBS urges state policymakers to recognize that obesity is a serious chronic disease and deserves to be treated with respect in the same fashion as diabetes, heart disease or cancer. Therefore, when crafting the benefit plan, please afford those affected by obesity with the same medically necessary treatment avenues afforded to all others who suffer from chronic disease.

End of Douglas O. Olsen, MD, FACS

President's Comment

State of Tennessee

Department of Commerce and Insurance

Mary Linden Salter, LCSW

Executive Director,

Tennessee Association of Alcohol, Drug and other Addiction Services

The Tennessee Association of Alcohol, Drug and other Addiction Services (TAADAS) is a statewide association of alcohol and drug abuse service professionals and providers. We represent over 41 treatment services providers statewide and over 15 professionals as individual members. On behalf of TAADAS I would like to submit the following comments and suggestions related to the Essential Health Benefits available under the Affordable Healthcare Act for Tennessee. We appreciate the opportunity to provide our perspective on this important decision being considered by your department.

As a direct consequence of drug use, 1,035 persons died in Tennessee in 2007. This is compared to the number of persons in Tennessee who died from motor vehicle accidents (1,303) and firearms (924) in the same year. Tennessee drug-induced deaths (16.8 per 100,000 population) exceeded the national rate (12.7 per 100,000) (Source: Centers for Disease Control and Prevention). Currently in Tennessee, there is a system of alcohol and drug (A&D) treatment and co-occurring diagnosis (mental health along with A&D) providers that offer a wide range of services to Tennesseans. These services can include inpatient detoxification services, residential treatment, intensive out-patient treatment as well as traditional weekly out-patient sessions. Someone with an A&D disorder can require care in several levels of care as they progress through the treatment continuum. Recovery is a long term commitment that requires regular maintenance and check-ups to use typical medical jargon. Current plans that could be considered as benchmarks for Essential Health Benefits provide a combined limit of 20 days yearly for Mental Health and A&D treatment or other similar limits. This limited treatment option is not adequate to treat the course of most A&D disorders in a year or in a lifetime. Many persons requiring A&D treatment use up their private insurance benefits and may go on to qualify and to utilize public programs such as the A&D Federal block grants, TennCare, Medicare or other public assistance for the additional

care they need. Providing for more adequate coverage under the Affordable Care Act would reduce such cost shifting and enable more persons in care to receive treatment while remaining employed, in school and productive – not qualified as disabled and receiving public benefits. Federal Block grants that have served this population will likely be cut with the implementation of the ACA. Planning for the benefits package needs to take into account that these Tennesseans who have been treated under Federal programs would not be served if the Essential Benefits package does not contain adequate coverage. TAADAS members understand that under the ACA, all Tennessee Insurance plans' use of annual limits will be tightly regulated to ensure access to needed care. Please consider making any limit more reflective of actual A&D service utilization. One of the largest benefits of the Affordable Care Act is the benefit to providing preventative and timely care to a population that has not, for the most part, enjoyed regular or routine insurance coverage. Insuring new populations can actually save money. An example would be the beginning of the TennCare program. When TennCare added almost 500,000 new enrollees in 1994, the program budget rose only slightly. By ensuring that programs run efficiently and responsibly, we can get more health care for every dollar spent. Early A&D intervention and treatment saves lives and saves money when illnesses are treated within a treatment and recovery support network. Mandates for preventative services under the ACA now include domestic and interpersonal violence screening and counseling for all women at no cost, alcohol and drug use assessments for adolescents and behavioral assessments for children of all ages. These assessments will identify issues that need ongoing A&D intervention.

The current private insurance funded A&D service system primarily provides treatment when a person is in crisis and has an acute treatment need according to medical necessity criteria. But we know that prevention efforts provide better outcomes and lessen the onset, impact and course of any disease. A&D treatment is most successfully provided using a recovery based continuum of care that includes a full spectrum of facility based treatment, out-patient treatment, Peer Support Services and Recovery Housing. These recovery oriented and Peer lead programs that provide needed

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

habilitation supports have been shown to provide enhanced outcomes for long term success in the community for those we treat. The TennCare program currently provides recovery support services such as Supportive Housing and Peer Support Services to those diagnosed with a mental health disorder. Tennessee recently received a SAMHSA grant to develop a similar service to address the needs of persons with A&D and co-occurring disorders. We urge you to consider modifying any benchmark plan chosen to include a full recovery based continuum of behavioral health care and we are happy to provide you with additional detail as to the programs and services that constitute such a continuum.

Tennessee has undertaken several efforts lead by Governor Haslam's Safety Cabinet to address the epidemic over-prescription and abuse of prescription pain killers. We applaud these efforts. In 2007-2008, Tennessee ranked first among all states for past-year non-medical use of pain relievers among persons age 26 or older. Tennessee also was one of the top ten states for rates in other drug-use categories, including past-month use of illicit drugs other than marijuana among persons age 12 and older (Source: National Survey on Drug Use and Health, 2007-2008). However, dependence on prescription pain killers is not typically a physical addiction. As a result, under insurance medical necessity guidelines (private insurance and TennCare) dependence on these drugs is not typically treated with detoxification programs or with residential treatment. Therefore, these addicts are most often treated in out-patient programs and must fail out-patient treatment several times before being considered for any facility based treatment. Again, we feel this type of addiction could better be treated within a full continuum of treatment and recovery based services. This current policy does not take into account the full cost to Tennessee for the interventions undertaken with this population. It results in increased costs for those failures in treatment and increased cost for the wasted time when other interventions are more effective. This affects costs in other segments of the community and our legal system, as well as increasing medical costs of treatment for both the continued addiction and the physical health issues caused. A&D treatment is most effective and cost effective when provided as a comprehensive system of support. We would support using the American Society of Addiction Medicine (ASAM) criteria as the medical necessity criteria for the A&D services defined as Essential Health Benefits. ASAM criteria define the full spectrum of care needed to provide effective interventions.

Currently most private insurance plans are reluctant to provide facility based treatment for A&D dependence or abuse for children or adolescents. There is often little support for these services due to deeply held beliefs that adolescents are merely acting out and are not truly dependent. The new mandates for alcohol and drug use assessments for adolescents and behavioral assessments for children of all ages will increase the number of children with identified A&D treatment needs. But without adequate and accessible benefits, these problems will only exacerbate and become more chronic into early adulthood – when they are harder to treat. We do not support total benefit limits for services to children or for A&D services in particular for children as A&D issues are the most overlooked for this population and as a result, often the last issues to be identified and provided.

The Governor's Safety Cabinet was referred to earlier in this letter. The strategy of including Commissioner's whose departments were addressing components of the prescription drug abuse epidemic was very effective in collectively addressing this issue. This initiative was one of the Governor's most successful to date. We feel that a similar strategy would be effective in addressing the selection of Essential Health Benefits under the ACA. As also stated earlier, addiction issues affect the services provided and the costs of those services in the legal system, our jails, the schools, the physical health system, and the public safety in our communities as well as our roads. The decision making to select these benefits would be best informed by knowledge of the existing issues in all these areas and any existing programs that would affect A&D service delivery. We urge the Department of Commerce and Insurance to advocate for the formation of a cabinet level group that could address A&D service needs, and perhaps other public health needs in all sectors of community programming across Tennessee.

State of Tennessee

Department of Commerce and Insurance

TAADAS appreciates your consideration of our comments regarding the choice of an Essential Benefits package. We would be happy to provide you with any additional information regarding the points addressed or regarding the current service system. Please contact me at 615-780-5901, ext. – 18 or at marylinden@taadas.org with any question you might have.

End of Mary Linden Salter, LCSW

Executive Director's Comment

State of Tennessee

Department of Commerce and Insurance

Cathy Baggett

Educational Resource Coordinator &

Patient Advocate

for the bleeding disorders community,

Company/Organization Not Supplied

Hemophilia and other bleeding disorders are complex conditions for which there is no known cure. Patients often require life-long infusions of clotting factor therapies that replace missing or deficient blood proteins, thus preventing debilitating and life-threatening internal bleeding. While therapies are safe and more effective than ever, they are also more costly than other types of medication.

Hemophilia is treated with factor replacement therapy. This therapy involves the injection of blood clotting products to replace the missing or deficient protein needed for the blood to clot. Infusions must be given as soon as possible after the start of bleeding. Alternatively, the patient can take regular doses of factor as a preventative treatment.

It is essential that the patient have access to choice of specialty pharmacy provider and not be restricted by exclusive pharmacy provider contracts because hemophilia is a very specialized disorder. Therefore it is important that the patient's pharmacy provider be highly specialized too. It is also important for patients to have access to every available clotting factor concentrate according to the choice of their physician and what is working best in meeting their medical needs, not just the cheapest one available.

We interpret the word "essential" as any medical treatment, procedure, service, as well as equipment and supplies indicated and approved by the United States Food and Drug Administration (FDA), for the care of patients with that specific diagnosis or follows generally accepted medical standards. The Hemophilia Federation of America recommends that the state of Tennessee take the following into consideration when evaluating what will be included in essential health benefits:

☐ STANDARDS OF CARE

☐ COMPREHENSIVE CARE

☐ MEDICAL NECESSITY DETERMINATIONS, APPEALS, AND GRIEVANCES PROCESSES

☐ LIMITS ON BENEFITS

☐ STATE MANDATES

☐ UPDATING ESSENTIAL HEALTH BENEFITS

☐ COST SHARING

STANDARDS OF CARE

For patients with rare and chronic conditions such as bleeding disorders, essential health benefits should be based on medical literature and treatment guidelines recommended by medical and patient organizations. An example of such a standard for individuals with bleeding disorders is MASAC #188 from the Medical and Science Advisory Committee at the National Hemophilia Foundation (Attached to this email). This standard of service for pharmacy providers as a minimum expectation for any insurer contracting with a pharmacy to provide factor concentrates for home use to patients with bleeding disorders.

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

COMPREHENSIVE CARE

The essential health benefits package should allow patients' access to needed specialists and allow the physician to formulate the best treatment regime for patients at the appropriate site of care whether in the hospital, outpatient clinic, office of the physician, hemophilia treatment center, or the home setting. It is important to note that specialized treatment facilities, such as the federally recognized hemophilia treatment centers (HTCs), do not fit neatly into specific categories of service. There are five HTC in the state of Tennessee. HTCs provide comprehensive, multi-disciplinary services in a single setting and have been shown through research at the Centers for Disease Control (CDC) to improve quality and reduce morbidity and mortality of individuals living with bleeding disorders. Allowing access to comprehensive care centers such as these ensures that the most appropriate balance of care is provided to the patient by medical professionals.

MEDICAL NECESSITY DETERMINATIONS, APPEALS, AND GRIEVANCES

Requirements for plans to use medical necessity criteria should be objective, clinically valid, and compatible with generally accepted principles of care. The essential health benefits package should always include a process to appeal a claim denial. That process should provide assurance that the insurer has an obligation to consult the patient's physician to discuss a possible denial and the grounds for that decision.

LIMITS ON BENEFITS

The HFA opposes additional limits on specific or total benefits in the package. We recommend prohibiting treatment caps, prior authorization, utilization management or other restrictions by cost or in limits on treatments (in particular those approved by the FDA). The mechanisms are used by some insurance companies use to limit patient access to treatments, particularly when the treatment is very costly. For patients with bleeding disorders, their treatment is not only lifesaving but also very expensive, and there are no generic alternatives. Delay in treatment can lead to disabling consequences and even death.

STATE MANDATES

Mandated coverage options in Tennessee have been invaluable to rare, chronic and high-cost disease groups, who might otherwise be excluded from private coverage. Any decision to phase out a state mandate must be informed by possible disruptions in coverage that might ensue.

COST SHARING

It is vital for patients with rare diseases to choose a health insurance policy that will meet their unique needs. Therefore, Tennessee's exchange should require plans to disclose all information about the deductible, co-payment and co-insurance amounts that are applicable to in-network and out-of-network covered services as well as any limitations on services. In addition, Tennessee's exchange should prohibit specialty tier pricing for prescription drugs, and/or plans should offer protections for these high out-of-pocket costs by providing tier exceptions.

If followed, the above recommendations will result in essential health benefits that promote quality, affordable care for the bleedings disorders community in Tennessee.

End of Cathy Baggett

Educational Resource Coordinator &

Patient Advocate

for the bleeding disorders community's Comment

Last Revision: Tuesday, August 21, 2012

State of Tennessee

Department of Commerce and Insurance

Sarah B. Canale

Clinical Dietitian,

Methodist LeBonhuer Healthcare System

I believe licensed registered dietitians should be included in the Essential Health Benefits law. I work in Memphis with obese patients everyday that are trying to qualify for a kidney or liver transplant. Many of these patients have weight-related illnesses such as hypertension, diabetes, back and knee pain and surgeries, depression, heart disease and a host of other complications. Obesity in TN and the US is costing millions of dollars in health care complications.

Registered dietitians have the expertise to address obesity. They not only have the knowledge of the body and how food is digested and metabolized, but have the knowledge of diets and disease. They are able to assist clients in making gradual change in their eating patterns, while addressing such things as diabetes, so that they can eventually lose weight and be healthier.

Additionally, obesity in children is very high in TN. Overweight children are more likely to become overweight adults and thus face complications. In fact, obese children have been found to have high cholesterol and heart disease. The Dietetic Internships in TN, of which there are 7, are working collaboratively to provide nutrition instruction to children and parents in order to prevent or reverse obesity in childhood. Nutrition instruction at an early age has proved to be beneficial.

As a state, and you as a committee/lawmaker, need to do everything within our power to stop this obesity trend. Registered Dietitians are the experts and are willing to help, so please include us in the Essential Health Benefits.

End of

Sarah B. Canale

Clinical Dietitian's Comment